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ABSTRACT

This Kids Count databook is the seventh annual profile examining statewide trends in the well-being of Rhode Island's children. The statistical portrait is based on 43 indicators in 5 areas: (1) family and community (including child population and children in single-parent families); (2) economic well-being (including median household income, secure parental employment, child poverty, child support, children in the Family Independence Program, children in families receiving food stamps, and children receiving school breakfast); (3) health (including children's health insurance, dental care access, mental health, WIC, prenatal care, birthweight, infant mortality, lead poisoning, asthma, births to teens, and alcohol, drug, and cigarette use by teens); (4) safety (including child and teen deaths, homeless children and youth, juveniles referred to family court, child abuse and neglect, and out-of-home placement); and (5) education (including infant/preschool child care, Head Start enrollment, school-age child care, child care subsidies, special education enrollment, fourth-grade reading skills, school attendance, and high school graduation). The report defines each indicator, describes its significance and trends, provides information on intervention programs, and presents relevant data for the state, 39 cities and towns, and an aggregate of the 5 cities with the highest child poverty rates. The report concludes with a description of the

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methodology, a list of Kids Count committee members, and acknowledgements. (KB)

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2001 Rhode Island Kids Count Factbook

Rhode Island KIDS COUNT is a children's policy organization that provides information on child well-being, stimulates dialogue on children's issues, and promotes accountability and action. Primary funding for Rhode Island KIDS COUNT is provided by The Rhode Island Foundation and The Annie E. Casey Foundation. Additional funding is provided by the United Way of Southeastern New England, Prince Charitable Trusts, the Northeast and Islands Regional Educational LAB at Brown University, The Robert Wood Johnson Foundation, The David and Lucile Packard Foundation, CVS/pharmacy and other corporate, foundation and individual sponsors.

The annual *Rhode Island KIDS COUNT Factbook* is one of fifty state-level projects designed to provide a detailed community-by-community picture of the condition of children. A national Factbook with comparable data for the U.S. is produced annually by The Annie E. Casey Foundation.

Additional copies of the *2001 Rhode Island KIDS COUNT Factbook* are available for $15.00 per copy. Reduced rates are available for bulk orders. To receive copies of the *2001 Factbook*, please contact:

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**New Indicator*

Overview

Barter

By Sara Teasdale

Life has loveliness to sell,
All beautiful and splendid things,
Blue waves whitened on a cliff,
Soaring fire that sways and sings,
And children's faces looking up
Holding wonder like a cup.

Life has loveliness to sell,
Music like a curve of gold,
Scent of pine trees in the rain,
Eyes that love you, arms that hold,
And for your spirit's still delight,
Holy thoughts that star the night.

Spend all you have for loveliness,
Buy it and never count the cost;
For one white singing hour of peace
Count many a year of strife well lost,
And for a breath of ecstasy
Give all you have been, or could be.

The *2001 Rhode Island KIDS COUNT Factbook* is the seventh annual profile of the well-being of children in Rhode Island. The annual Factbook is an important tool for planning and action by community leaders, policy makers, advocates, and others working toward changes that will improve the quality of life for all children.

The annual Factbook tracks progress across five areas of child well-being. All areas of child well-being are interrelated and critical throughout a child's development. A child's safety in his family and community affects his school performance; a child's economic security affects her health and education. The *2001 Rhode Island KIDS COUNT Factbook* reflects these interrelationships and builds a framework to guide policy, programs for children, and individual service on behalf of children.

The *2001 Rhode Island KIDS COUNT Factbook* provides a statistical portrait of the status of Rhode Island's children. Information is presented for the state of Rhode Island, each city and town, and an aggregate of the five cites in which more than 15% of the children live in poverty. These cities — referred to as the "core cities" in the Factbook — are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The Factbook provides community-level information on each indicator in order to emphasize the significance of the surrounding physical, social, and economic environment in shaping outcomes for children. Communities and neighborhoods do matter - the actions of community leaders, parents, individuals, businesses, government leaders, and elected officials greatly influence children's chances for success and the challenges they will face.

By examining the best available data statewide and in Rhode Island's 39 cities and towns, Rhode Island KIDS COUNT provides an information base that can result in more effective policy and community action on behalf of children. Tracking changes in selected indicators can help communities to set priorities, identify strategies to reverse negative trends, and monitor progress.

The *2001 Rhode Island KIDS COUNT Factbook* examines forty-three indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety, and Education. Six new indicators are included in this edition of the Factbook. The most current and reliable data available are presented for each indicator.

Educational Attainment

Improving student achievement and high school graduation rates in Rhode Island requires that all sectors work together to provide opportunities for infants, young children, and teens in the state's high poverty neighborhoods. Young people who complete high school prepared to go on to higher education or to enter the workforce are more likely to be capable, self-sufficient adults who contribute to the community. Children who participate in high-quality preschool programs and read at grade level by fourth grade are more likely to complete high school. Student achievement can be improved when schools have high expectations for all students, effective curricula and teaching methods, adequate accountability methods, and prepared and sufficiently supported teachers.

Family Economic Security

Children most at risk of not achieving their full potential are children in poverty. Despite overall economic growth in the past decade, many Rhode Island families have experienced income losses since the late 1980s. The child poverty rate has increased from 14% in 1990 to 18% in 1998. More than half of Rhode Island's 40,231 poor children live in extreme poverty - with a family income less than $8,525 (half of the federal poverty level of $17,050 for a family of four). Even those with incomes above the official poverty level have a difficult time making ends meet due to the high costs of housing, utilities, child care, and health care. Child care subsidies, health care subsidies, affordable housing, and tax policies that support working families are critical tools to ensure the economic well-being of Rhode Island families.

Results for All Children

Significant racial and ethnic disparities in child outcomes continue to exist in Rhode Island. Black, Hispanic, Asian and Native American children are more than twice as likely as White children to be poor and more likely to live in Rhode Island's poorest urban neighborhoods. Strategic efforts that engage diverse leadership can ensure that all Rhode Island children have the resources they need to thrive, including economic security, effective schools, quality child care, quality health care, affordable housing, and caring communities.

Family and Community

The Home

By Rabindranath Tagore

I paced alone on the road across the field
while the sunset was hiding its last gold
like a miser.

The daylight sank deeper and deeper into the darkness, and the widowed land, whose harvest had been reaped, lay silent.

Suddenly a boy's shrill voice rose into the sky. He traversed the dark unseen, leaving the track of his song across the hush of the evening.

His village home lay there at the end of the waste land, beyond the sugar-cane field, hidden among the shadows of the banana and the slender areca palm, the cocoa-nut and the dark green jack-fruit trees.

I stopped for a moment in my lonely way under the starlight, and saw spread before me the darkened earth surrounding with her arms countless homes furnished with cradles and beds, mothers' hearts and evening lamps, and young lives glad with a gladness that knows nothing of its value for the world.

Child Population

DEFINITION

Child population is the percentage of the total population that is under the age of 18.

SIGNIFICANCE

In 1998, nearly one-quarter of the Rhode Island population was under age 18. There were 227,753 Rhode Island children under age 18.[1] Of these, 6% were infants less than age one; 28% were ages 1 to 5; 36% were ages 6 to 11; and 31% were ages 12 to 18.[2] The number of children in Rhode Island is projected to increase by 5% between 1997 and 2005.[3] Over the next decade, the number of Rhode Island teenagers will grow by 20%, while the number of younger children ages birth to 12 will drop by 2%.[4]

In the United States since 1960, both the percentage of families with children and the average family size have decreased. Between 1960 and 1998, the percentage of families with four or more children under age 18 decreased from 9% to 3%, while the percentage of families with no children increased from 43% to 51%.[5] In 1998, 67% of Rhode Island children lived with both parents, 27% lived with their mother only, and 4% lived with their father only.[6]

Rhode Island's children are diverse in race, ethnic background, language, and country of origin. Children under age 18 are significantly more diverse in racial and ethnic backgrounds than the adult population. In 1998, 88% of Rhode Island children were White, 7% were Black, 4% were Asian, and less than 1% were American Indian. Of Rhode Island's 227,753 children, 11% were Hispanic.[7]

Rhode Island, and the U.S. as a whole, will continue to grow more diverse during the next century. According to the U.S. Census Bureau projections, the Hispanic population will become the largest minority group in the U.S. by 2005 and the Asian population is the fastest growing group in the United States. By 2050, Hispanics will make up 24% and Asians will make up 9% of the total U.S. population.[8]

In 2000, there were 28.4 million foreign-born people residing in the U.S.. An estimated 3 million of these were children under 18. An even larger number of children live in families with foreign-born parents.[9] The Immigration and Naturalization Service estimates that an additional 5 million people live in the United States without legal documentation.[10] Between 1980 and 1998, nearly three-quarters of all immigrants granted permission to enter the United States came from Asia and Latin America; another 4% came from Africa and 20% came from Europe.[11]

Immigration in Rhode Island

◆ In 1998, Rhode Island was home to 97,435 immigrants. Of these, 6,641 were under 18 years of age, 3% of all children in the state. Of Rhode Island households with children, 45,674 were headed by immigrants.[12] These numbers do not include immigrants that reside in the state without documentation.

◆ Due to both immigration and increased birth rates, it is expected that between 1997 and 2005 the number of Hispanic children in Rhode Island will increase by 52% (from 22,700 to 34,400) and the number of Asian children in Rhode Island will increase by 75% (from 6,900 to 12,100).[13]

Immigrant Families and Access to Services

◆ Compared to children born in the U.S., children in immigrant families are more likely to be poor, more likely to live in a household with more than five people, and less likely to have parents who have graduated from high school.[14] Although they are more likely to be bilingual, they are much less likely to be proficient in English.

◆ Immigrant families, both with and without legal documentation, are eligible for a wide range of programs in the social safety net.[15] These families often do not access programs due to a lack of knowledge about their eligibility, language barriers, or fear that they may be penalized for seeking the help they need.

◆ Recent changes in Immigration and Naturalization Service (INS) regulations allow immigrants to receive certain non-cash benefits without adverse effects on their immigration status. Non-cash benefits include Medicaid, RIte Care, Food Stamps, WIC, housing assistance, energy benefits, job training, educational assistance, Head Start, and child care.[16]

◆ To comply with the U.S. Civil Rights Act, all federally-funded agencies must ensure that individuals who are limited in their English proficiency have "meaningful access" to services. Language assistance that results in "accurate and effective" communication must be provided at no-cost to the individual.[17]

Table 1

Child Population, Rhode Island, 1999

CITY/TOWN	TOTAL POPULATION	CHILDREN UNDER AGE 18	
		N	%
Barrington	15,946	3,896	24%
Bristol	21,495	4,317	20%
Burrillville	14,797	4,215	28%
Central Falls	16,236	4,603	28%
Charlestown	7,536	1,795	24%
Coventry	31,044	7,682	25%
Cranston	72,761	14,079	19%
Cumberland	28,287	6,338	22%
East Greenwich	11,007	2,653	24%
East Providence	48,645	10,351	21%
Exeter	5,983	1,672	28%
Foster	4,304	1,175	27%
Glocester	8,247	2,257	27%
Hopkinton	7,560	2,035	27%
Jamestown	5,368	1,228	23%
Johnston	25,510	5,294	21%
Lincoln	18,265	3,918	21%
Little Compton	3,265	701	21%
Middletown	17,359	4,487	26%
Narragansett	17,019	3,206	19%
Newport	25,890	5,437	21%
New Shoreham	834	178	21%
North Kingstown	26,900	6,809	25%
North Providence	31,142	5,641	18%
North Smithfield	9,722	2,088	21%
Pawtucket	69,613	16,093	23%
Portsmouth	17,705	4,387	25%
Providence	152,698	37,195	24%
Richmond	5,580	1,610	29%
Scituate	10,845	2,635	24%
Smithfield	19,451	3,958	20%
South Kingstown	26,432	5,152	19%
Tiverton	13,746	2,988	22%
Warren	11,582	2,487	21%
Warwick	86,240	18,811	22%
Westerly	24,128	5,666	23%
West Greenwich	4,341	1,147	26%
West Warwick	29,195	6,696	23%
Woonsocket	41,175	10,101	25%
Core Cities	*305,612*	*73,429*	*24%*
Remainder of State	*682,241*	*151,552*	*22%*
Rhode Island	*987,853*	*224,981*	*23%*

Source of Data for Table/Methodology

Geolytic estimates for 1999 using data from the U.S. Bureau of the Census, 1990 Census of Population. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls. The denominator is the total population in 1999 according to Geolytic estimates.

See methodology on page 110 for additional information on Geolytic estimates.

References for Indicator

[1,2,3,4,5] U.S. Bureau of the Census, Current Population Survey, 1996 to 2000 average.

[2,3] *1999 KIDS COUNT Data Book: State Profiles of Child Well-Being* (1999). Baltimore, MD: The Annie E. Casey Foundation.

[4] *1998 KIDS COUNT Data Book: State Profiles of Child Well-Being* (1998). Baltimore, MD: The Annie E. Casey Foundation.

[5] *Trends in the Well-Being of America's Children and Youth* (1999). Washington, DC: U.S. Department of Health and Human Services.

[6] *U.S. Department of Commerce News. Census Bureau Projects Doubling of the Nation's Population by 2100* (January 13, 2000). Washington, DC: U.S. Bureau of the Census.

[6,14] *The Foreign-Born Population in the United States* (March 2000). Washington, DC: U.S. Bureau of the Census.

[10] *Immigration Reform: The Basics* (2000). New York, NY: The Twentieth Century Fund, Inc./The Century Foundation, Inc.

[11] Pollard, K. M. and O'Hare, W.P. (September 1999). "America's Racial and Ethnic Minorities" in *Population Bulletin*, Vol. 54, No. 3. Washington, DC: Population Reference Bureau.

[13] *Rhode Island Department of Human Services Manual - General Provisions (2001)*. Providence, RI: Rhode Island Department of Human Services.

[14] Fremstad, S. (January 2000). *The INS Public Charge: What Does It Mean For Immigrants Who Need Public Assistance?* Washington, DC: Center on Budget and Policy Priorities.

[15] *Policy Guidance on the Title VI Prohibition Against National Origin Discrimination as it Affects Persons with "Limited English Proficiency" (LEP)* (2000). Washington, DC: US Department of Health and Human Services, Office of Civil Rights.

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Children in Single Parent Families

DEFINITION

Children in single parent families is the percentage of children under age 18 who live in families headed by a person – male or female – without a spouse present in the home. These numbers include "own children" defined as never-married children under 18 who are related to the family head by birth, marriage, or adoption.

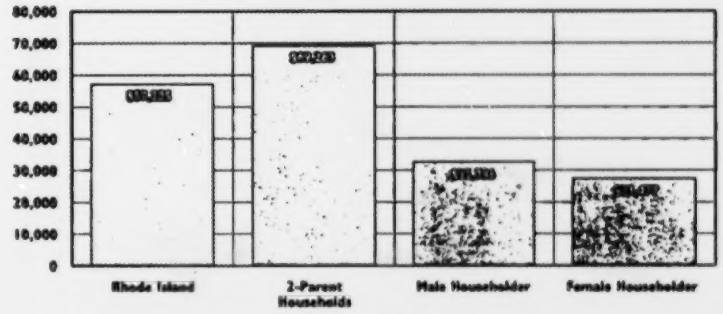
SIGNIFICANCE

Although most Rhode Island children live with two parents, 31% lived in a single parent family in 1998.[1] This includes 28% of White children, 55% of Black children, and 61% of Hispanic children. Black and Hispanic children in Rhode Island are about twice as likely to live in a single-parent family as White children.[2]

The proportion of children living with one parent has more than doubled since 1970. The increase in single parent families over the past three decades has occurred across all races and income levels.[3] More than half of all children are likely to have spent significant portions of their childhood living apart from their fathers before they reach 18.[4] Nationally, of the children living with one parent, 36% live with a divorced parent, 39% live with a never-married parent, 16% live with a separated parent, 4% with a widowed parent and 5% have a parent who lives elsewhere because of business or some other reason.[5] Never-married parents are significantly younger than divorced parents and on average tend to have fewer years of school completed and lower levels of income.[6] In 1999 in Rhode Island, 38% of all births were to unmarried women.[7]

Children in single parent families are at increased risk of living in poverty when compared to children in two-parent families. In 1998, 44% of Rhode Island's single parent families with children were living below the poverty line, as compared to 3% of two-parent families with children.[8] Seventy-one percent of children living below the poverty line lived with a single mother.[9] Compared with teenagers who grow up with both parents at home, adolescents who have lived apart from one of their parents during some period of their childhood are much more likely to drop out of school or be teen parents regardless of race or maternal education.[10]

Average Household Income for Families with Children, Rhode Island, 1998



◇ In 1998, the average household income in Rhode Island for two-parent families with children was $69,263 compared to $32,736 for single parent families headed by a man and $27,477 for single parent families headed by a woman.

Source: U.S. Bureau of the Census, Current Population Survey, 1996 to 2000 average.

Children Living in the Home of Their Grandparents

◇ Since 1970, there has been a marked increase in the number of children living in the home of their grandparents. In 1970, 3.2% of all children lived in the homes of their grandparents. By 1999, this had increased to 5.4% of all children.[11]

◇ Nationally, about one third of these grandparent-headed households do not include the child's parents. Just under one-half (46%) are grandparent-headed households with the child's mother only present.[12]

◆ In Rhode Island, 4% of children live in a household headed by their grandparent. In 1998, there were approximately 9,700 Rhode Island children living in their grandparent's home.[13]

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Table 2.

Children's Living Arrangements, Rhode Island, 1990

CITY/TOWN	TOTAL FAMILY HOUSEHOLDS WITH CHILDREN UNDER 18	NUMBER OF CHILDREN UNDER 18 YEARS: TWO-PARENT FAMILY N	TWO-PARENT FAMILY %	SINGLE PARENT FAMILY N	SINGLE PARENT FAMILY %
Barrington	2,035	3,514	94.4%	207	5.6%
Bristol	2,300	3,660	88.9%	457	11.1%
Burrillville	2,314	3,824	87.2%	560	12.8%
Central Falls	2,373	2,859	61.7%	1,778	38.3%
Charlestown	833	1,244	83.0%	254	17.0%
Coventry	3,979	6,290	87.2%	920	12.8%
Cranston	7,911	11,360	81.2%	2,622	18.8%
Cumberland	3,491	5,551	90.2%	604	9.8%
East Greenwich	1,609	2,521	88.3%	335	11.7%
East Providence	5,766	7,950	81.7%	1,776	18.3%
Exeter	768	1,278	90.6%	132	9.4%
Foster	591	988	88.2%	132	11.8%
Glocester	1,320	2,036	88.6%	261	11.4%
Hopkinton	930	1,557	90.2%	170	9.8%
Jamestown	623	907	83.4%	181	16.6%
Johnston	2,851	4,229	81.7%	945	18.3%
Lincoln	2,181	3,210	86.1%	518	13.9%
Little Compton	420	612	89.7%	70	10.3%
Middletown	2,429	3,774	85.1%	659	14.9%
Narragansett	1,551	2,227	85.2%	387	14.8%
Newport	3,086	3,569	65.0%	1,920	35.0%
New Shoreham	97	149	88.7%	19	11.3%
North Kingstown	3,299	4,943	85.1%	864	14.9%
North Providence	3,115	4,563	86.6%	706	13.4%
North Smithfield	1,284	1,935	91.1%	188	8.9%
Pawtucket	8,957	11,266	73.9%	3,976	26.1%
Portsmouth	2,429	3,749	91.7%	339	8.3%
Providence	17,948	19,292	56.2%	15,054	43.8%
Richmond	791	1,344	94.9%	72	5.1%
Scituate	1,275	2,079	90.1%	228	9.9%
Smithfield	2,095	3,324	91.0%	330	9.0%
South Kingstown	2,603	3,681	81.8%	819	18.2%
Tiverton	1,727	2,477	84.0%	472	16.0%
Warren	1,356	1,880	83.8%	364	16.2%
Warwick	9,505	14,477	83.6%	2,835	16.4%
Westerly	2,746	4,071	85.7%	680	14.3%
West Greenwich	464	715	86.0%	116	14.0%
West Warwick	3,529	4,711	77.3%	1,386	22.7%
Woonsocket	5,650	6,850	68.6%	3,140	31.4%
Core Cities	*38,014*	*43,836*	*62.8%*	*25,868*	*37.1%*
Remainder of State	*80,217*	*120,830*	*85.4%*	*20,608*	*14.6%*
Rhode Island	*118,231*	*164,666*	*78.0%*	*46,476*	*22.0%*

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the number of children under age 18 according to the 1990 Census of Population.

References for Indicator

[1,2,3,4,5] U.S. Bureau of the Census, Current Population Survey, 1996 to 2000 average.

[2] Census of Population, 1970, 1980, 1990. Washington, DC: U.S. Bureau of the Census.

[4] *The Economic Report of the President* (2000). Washington, DC: U.S. Council of Economic Advisors.

[5] *Unpublished Tables – Marital Status and Living Arrangements: March 1998 (Update)* (1998). Washington, DC: U.S. Bureau of the Census.

[6] *Census Brief: Children with Single Parent Families - How They Fare* (1997). Washington, DC: U.S. Bureau of the Census.

[7] Rhode Island Department of Health, Division of Family Health, Universal Newborn Screening Database, 1999.

[10] McLanahan, S. and Sandefur, G., *Growing Up With a Single Parent* (1994), as quoted in *Kids Count Special Report - When Teens Have Sex: Issues and Trends* (1999). Baltimore, MD: Annie E. Casey Foundation.

[11] *Population Today* Vol. 27, No. 12. (December 1999) Washington, DC: Population Reference Bureau.

[12] *Current Population Reports: Grandchildren Living in the Home of Their Grandparents: 1970 to Present* (January 1999). Washington, DC: US Bureau of the Census.

Racial and Ethnic Disparities

DEFINITION

Racial and ethnic disparities is the gap that exists in outcomes for children of different racial and ethnic groups in Rhode Island. Child outcome areas include economic well-being, health, education, and safety.

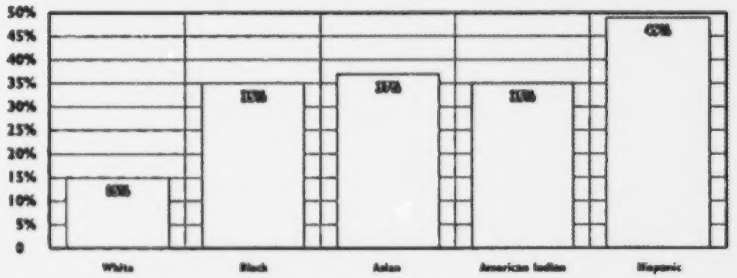
SIGNIFICANCE

Rhode Island's children are diverse in race, ethnic background, language, and country of origin. Although there have been substantial improvements in child well-being over the last century across racial and ethnic lines, large disparities still exist between White, non-Hispanic children and children from other racial and ethnic groups. Race and ethnicity continue to be strong predictors of well-being in the United States and in Rhode Island.[1]

Black, Hispanic, American Indian and Asian children are more likely to be poor and to have parents with lower education levels.[2] Poverty adversely impacts nearly all indicators of child well-being tracked by KIDS COUNT. Poor health interferes with a child's quality of life, educational opportunity, and future earning potential.[3] Low educational attainment results in poor economic prospects as young people grow into adulthood and become parents themselves.[4]

Racial and ethnic minority groups continue to be disproportionately represented in the child welfare and juvenile justice systems. Research shows that Black youth are more likely than White youth to be placed in secure detention, even when the type and severity of the offense is the same.[5] National data indicate that poor families and families of color are more likely to have their child removed and placed in foster care. Once in foster care, children of color are more likely to remain there for longer periods of time and to experience multiple placements in different homes.[6] While Black children comprise 7% of the Rhode Island child population, they comprise 25% of the children in the foster care system and 22% of the youth incarcerated at the Rhode Island Training School. Hispanic children comprise 11% of Rhode Island's child population but represent 14% of the children in foster care and 25% of the children at the Training School.[7]

Children in Poverty, by Race and Ethnicity, Rhode Island, 1998



Note: Percentages are calculated within each racial and ethnic group.

Source: U.S. Bureau of the Census, Current Population Survey, 1996 to 2000 average.

◇ Although the majority of the poor children in Rhode Island are White, minority children are far more likely to be poor. Black, Asian and American Indian children are more than twice as likely as White children in Rhode Island to live in poverty. Hispanic children in Rhode Island are more than three times as likely as White children to be poor.[8]

◇ In 1998, there were 40,231 poor children in Rhode Island. Of these, 5,898 were Black, 11,895 were Hispanic, 3,141 were Asian, and 609 were Native American.[9]

◇ Children living in single parent families are much more likely to be poor. Black and Hispanic children in Rhode Island are about twice as likely to live in a single-parent family as their White counterparts. In 1998, in Rhode Island 28% of White children, 55% of Black children, and 61% of Hispanic children lived in single parent families.[10]

◇ Black and Hispanic men and women earn less than White, non-Hispanics even when they have comparable education levels. Minority populations possess far fewer financial assets (such as savings, equity in a home or retirement plan).[11,12]

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Health Outcomes, by Race and Ethnicity, Rhode Island, 1995-1999

	WHITE	BLACK	HISPANIC	ASIAN	ALL RACES
Women with Delayed Prenatal Care	8.3%	17.2%	13.9%	15.6%	9.3%
Births to Teens Ages 15-17 (per 1,000 teens)	23	72	121	69	27
Infants Born Low Birthweight	6.6%	11.4%	7.5%	8.3%	7.2%
Infant Mortality Rate (per 1,000 live births)	5.9	12.2	8.2	6.9	6.4
Children Hospitalized for Asthma (per 1,000 children)	1.5	3.2	3.9	2.0	2.1

Source: Rhode Island Department of Health, Office of Family Health, 1995-1999 (prenatal care, teen births, low birthweight, infant mortality); and Hospital Discharge Database, 1999 (asthma hospitalization).

◇ In Rhode Island, minority women are less likely to receive early prenatal care and more likely to give birth as teens. Black, Hispanic and Asian children are more likely to be born low birthweight, to die in the first year of life, to suffer from lead exposure, and/or to be hospitalized for asthma.[12]

◇ In 1996 in Rhode Island, 9% of White adults were uninsured as compared with 18% of Blacks, 24% of Hispanics, and 23% of Asians.[13] Comparable data for Rhode Island children are not available. Nationally, Hispanic children and poor children are the most likely to be uninsured.[14]

Education Outcomes, by Race and Ethnicity, Rhode Island, 1999-2000

	WHITE	BLACK	HISPANIC	ASIAN	ALL RACES
Kindergarten Children with High Lead Levels (>=10ug/dL)	11%	28%	19%	26%	13%
4th Grade Children Meeting the Standard for Reading:					
Basic Understanding	86%	64%	57%	73%	78%
Analysis and Interpretation	73%	44%	39%	54%	64%
High School Graduation Rate	86%	68%	62%	81%	82%

Source: Rhode Island Department of Health Office of Occupational and Radiological Health, 2000 (lead); Rhode Island Department of Elementary and Secondary Education.

◇ During the 1998-1999 school year, 76% of public school students in Rhode Island were White, 8% were Black, 13% were Hispanic, 3% were Asian and 1% were Native American.[15]

◇ Black and Hispanic youth are more likely to have low reading scores by fourth grade and are more likely to drop out of high school.[16] Blacks and Hispanics are less likely to enroll in college and less likely to complete college once enrolled. In Rhode Island, 32% of White 25- to 65-year-olds hold a bachelor's degree, compared to 16% for all other races.[17]

◇ The poverty rate for high school dropouts is three times that of high school graduates and ten times that of college graduates.[18] Research shows that school completion and academic success increase children's ability to escape poverty, form strong families, and raise successful children of their own.[19]

References for Indicator

[1,12,14] *1999 KIDS COUNT Data Book: State Profiles of Child Well Being* (1999). Baltimore, MD: The Anne E. Casey Foundation.

[2,3,4,13] *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (September 1998). Washington, DC: Council of Economic Advisors for the President's Initiative on Race.

[5] *Juvenile Offenders and Victims: 1999 National Report* (September 1999). Washington, DC: U.S. Department of Justice.

[6] American Bar Association (1993). *America's Children at Risk: A National Agenda for Legal Action*. Chicago: American Bar Association, Working Group on the Unmet Legal Needs of Children and Their Families.

[7] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), Foster Care Placements, December 31, 2000 and Rhode Island Training School for Youth, January 11, 2001.

[8,9,10] U.S. Bureau of the Census, Current Population Survey, 1996 to 2000.

[11] Pollard, K. and O'Hare, W. (1999) *America's Racial and Ethnic Minorities*. Washington, DC: Population Reference Bureau.

[15] Rhode Island Department of Health, Office of Health Statistics, *1996 Rhode Island Health Interview Survey*.

[16,18] Rhode Island Department of Elementary and Secondary Education, 1999-2000 school year.

[17] *Measuring Up 2000: The State-by-State Report Card for Higher Education* (2000) Washington, DC: National Center for Public Policy and Higher Education.

[19] *U.S. Census Brief* (1998). "Children without Health Insurance." Washington, DC: U.S. Bureau of the Census.

Economic Well-Being

Antigua Sabiduria

By Francisco X. Alarcon

después
de trabajar
todo el día

como
campesino
de sol a sol

ordeñando
vacas
dormilonas

lavando
limpiando
dando de comer

a todos los animales
los chiquitos
y los grandotes

reparando
cercas
acequias

escardando
regando
su maizal

mi tío Vicente
descansando por fin
en su mecedora

muy calmado
bajo las estrellas
nos decía:

"mañana
empezamos
todo de nuevo"

Ancient Wisdom

after
working
all day

as a farmer
from dawn
to dusk

milking
sleepy
cows

washing
cleaning
feeding

all the animals
the small ones
and the big ones

repairing
fences
waterways

weeding
watering
his cornfield

Uncle Vicente
finally resting
in his rocking chair

would tell us
very calmly
under the stars:

"tomorrow
we'll start
all over"

U

Median Household Income

DEFINITION

Median household income is the median annual income for Rhode Island households with children under 18. The median income is the dollar amount which divides the income distribution into two equal groups – half with income above the median and half with income below the median.

SIGNIFICANCE

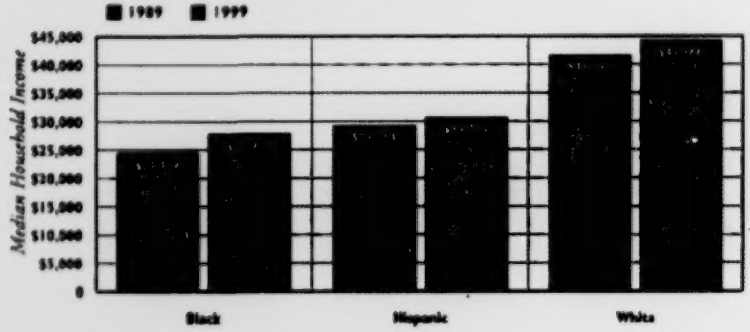
The median household income provides one measure of the ability of Rhode Island's families to meet the costs of food, clothing, housing, health care, transportation, child care, and higher education. In 1998, one-half of all Rhode Island families with children earned less than $46,930 and one-half earned more.[1]

Nationally, the median household income has increased 2.7% annually since 1996, after very little growth in the 1980's and 1990's.[2] In 1999, U.S. median household income hit an all time high while unemployment was at a 30-year low.[3] Recent increases in median family income nationally are largely the result of increases in total work hours – an additional seven weeks annually for the typical family since 1989. With more mothers working than ever before in history, families have increased their income either by more family members working and/or by working more hours each year.[4]

In 1998, 24% of Rhode Island households with children had incomes less than $25,000 and 10% had incomes between $25,000 and $35,000.[5] Due to the tight labor market and the increase in the minimum wage, very low-paid workers experienced slight wage increases between 1996 and 1998.[6] Despite the increase in wages that began in 1996, the wages of many low-income and middle-income families have not yet returned to 1989 levels. After adjusting for inflation, in 1999 the average low-wage worker in Rhode Island had earnings that were 2% below 1989 levels.[7]

Median household income increases with education level. In the U.S. in 2000, men with at least a college degree had a median income 3.6 times the median for men who did not complete high school. Women with a college degree had a median income 2.5 times as high as women who did not complete high school.[8] Women's earnings are below those for men in every occupational category for full-time, year round workers.[9] The gap between women's and men's wages increased during the economic boom of the late 1990's.[10]

Median Household Income, by Race and Ethnicity, United States, 1989 and 1999



Source: *Income 1999* (September 2000). Washington, DC: U.S. Bureau of the Census. All income data are in 1999 dollars. Race and ethnicity of the household is defined by the race and ethnicity of the head-of-household.

◆ Between 1989 and 1999 in the U.S., median household income levels have increased by 5% for all households in real dollars. Over the past decade, median income of Black households increased by 14% and median income of Hispanic households increased by 5%.[11]

◆ In 1999 in the U.S, the median household income for Black or Hispanic households continued to be one-third lower than for White, non-Hispanic households. The median income for Black households was 63% of the median income for White, non-Hispanic households. The median income for Hispanic households was 69% of the median income for White, non-Hispanic households.[11]

◆ Incomes of U.S. households headed by foreign-born individuals continue to be lower than incomes of households headed by individuals born in the U.S. The median household income for households headed by a person born outside the U.S. was $36,048 in 1999. This is 13% less (more than $5,000 less per year) than households headed by U.S.-born individuals.[12]

The Effects of Income Inequality

◇ Between the late 1980's and the late 1990's the average income of Rhode Island families in the bottom fifth of the income distribution fell by $3,781, a decline of 22%. During the same time period, the wealthiest fifth of families saw their incomes rise by $35,146, an increase of 28%.[14]

◇ Of all 50 states, the gap between the wealthiest 20% of families and the poorest 20% grew most in Rhode Island (followed by Oregon, Arizona, New York and Connecticut).[15]

◇ Communities with above-average income inequality have higher mortality rates than communities with comparable incomes and poverty rates but lower income inequality.[16]

◇ Income inequality can have a direct effect on the adequacy of housing. Economic growth can lead to more demand for housing and higher housing prices. Even as the economy grows, family incomes at the bottom of the income distribution are not rising fast enough to keep up with the cost of housing, leading to increased risk for homelessness.[17]

◇ Increased income disparities can lead to geographic segregation as wealthier families move to the suburbs. Because school systems depend heavily on local funding from property taxes, this can result in unequal school funding across districts.[18]

Source: Bernstein, J., McNichol, E.C., Mishel, L. et.al. (January 2000). *Pulling Apart: A State-By State Analysis of Income Trends.* Washington, D.C.: Center on Budget and Policy Priorities and the Economic Policy Institute.

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Table 3.

Median Household Income, Rhode Island, 1990

CITY/TOWN	MEDIAN INCOME
Barrington	$53,058
Bristol	$34,165
Burrillville	$37,156
Central Falls	$18,617
Charlestown	$36,040
Coventry	$37,230
Cranston	$34,528
Cumberland	$40,683
East Greenwich	$50,896
East Providence	$31,007
Exeter	$38,179
Foster	$40,795
Glocester	$40,000
Hopkinton	$36,737
Jamestown	$41,518
Johnston	$32,596
Lincoln	$37,082
Little Compton	$41,187
Middletown	$35,228
Narragansett	$35,545
Newport	$30,534
New Shoreham	$31,471
North Kingstown	$40,419
North Providence	$32,321
North Smithfield	$41,449
Pawtucket	$26,541
Portsmouth	$42,474
Providence	$22,147
Richmond	$40,975
Scituate	$45,170
Smithfield	$42,523
South Kingstown	$36,481
Tiverton	$36,170
Warren	$31,637
Warwick	$35,786
Westerly	$34,844
West Greenwich	$41,250
West Warwick	$31,625
Woonsocket	$25,363
Core Cities	*NA*
Remainder of State	*NA*
Rhode Island	*$32,181*

Note to Table

In Rhode Island in 1998, the median household income for all households was $46,930 according to the U.S. Bureau of the Census, Current Population Survey, 1996-2000 average. Updated data are not available at the city and town level.

Source of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population, 1989 dollars. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

References for Indicator

[13] U.S. Bureau of the Census, Current Population Survey, 1996 to 2000 average.

[14] Bernstein, J. and Mishel, L. (September 2000). *Income Picture Factsheet*. Washington, DC: Economic Policy Institute.

[15] *Poverty Rate Hits Lowest Levels Since 1979 as Unemployment Reaches a 30-Year Low* (October 2000). Washington, DC: Center on Budget and Policy Priorities.

[16] *Low Unemployment, Rising Wages Fuel Poverty Decline* (October 1999). Washington, DC: Center on Budget and Policy Priorities.

[17] Mishel, L. and Bernstein, J. (2000). *The State of Working America 2000-2001*. Washington, DC: Economic Policy Institute.

[18] *Educational Attainment in the United States (Update)* (March 2000). Washington, DC: U.S. Bureau of the Census.

[19] *The Status of Women in the States: Politics-Economics-Health-Demographics* (1996). Washington, DC: Institute for Women's Policy Research.

[20] Bouzy, H., *Economic Snapshot* (December 2000). Washington, DC: Economic Policy Institute.

[13,14,15] *Income 1999* (September 2000). Washington, DC: U.S. Bureau of the Census.

[14,15,16,17,18] Bernstein, J., McNichol, E.C., Mishel, L. et.al. (January 2000). *Pulling Apart: A State-By State Analysis of Income Trends.* Washington, DC: Center on Budget and Policy Priorities and the Economic Policy Institute.

Cost of Rent

DEFINITION

Cost of rent is the percentage of income needed by a low-income renter to cover the average cost of rent, including heat. Rent burdens over 30% are considered unaffordable.[1] A low-income renter is defined as income 30% below the 2000 median renter income.[2]

SIGNIFICANCE

Inadequate, costly or crowded housing has a negative impact on children's health, safety, education, and emotional well-being.[3] Housing that costs more than one-third of a family's income is considered to be unaffordable. Families paying higher percentages of their income for housing are likely to go without other basic necessities in order to pay their rent (or mortgage) and utilities. Any interruption in income or unexpected expense can place families at risk of eviction, doubling up with family members, or becoming homeless.[4] Children who move frequently are more likely to be absent from school, to fall behind in their school work, and to drop out of high school.[5,6]

Many of the units that might be affordable to a low-income family are in need of repair. Housing and building code violations disproportionately affect low-income families in urban communities. Common housing problems include roach and rodent infestation, lead exposure, faulty wiring, inadequate heating systems, plumbing problems or lack of major appliances. Children living in substandard housing are more at risk for injuries, lead poisoning, asthma and malnutrition.[8,9]

Rhode Island is one of the least affordable housing markets in the country.[10] High heating and electric bills are expected to decrease housing affordability this year.[11] Record numbers of very low-income households are using more than half their incomes for housing.[12] On average for a low-income renter in Rhode Island, rent for a two-bedroom apartment consumes 44% of income.[13]

As housing costs increased throughout the mid-to-late 1990's housing subsidies have decreased, expanding the affordable housing gap nationwide. Private homeowners who had accepted Section 8 housing vouchers for rent in the past are opting out of the program to capitalize on high rental prices.[14] The average wait for Section 8 housing subsidies in Rhode Island is four to five years.[15] Even when Section 8 vouchers become available, families are unable to leave homeless shelters and transitional housing facilities because there is a shortage of apartments available in the private market.[16]

Affordable Rents for Selected Income Levels, Rhode Island, 2000

Income Level	Annual Income 2000	Affordable Rent (30% of Income)
Median-Income Renter	$28,136	$703
Low-Income Renter	$19,695	$492
Poverty Level Family of Three	$14,150	$354
Working Full-Time at RI Minimum Wage	$12,792	$320
Maximum FIP Cash Assistance plus Food Stamps	$10,740	$269
Income Needed for Average RI Rent	*$28,600*	*$715*

Source: Rhode Island Housing, 2001. Calculations by Rhode Island KIDS COUNT

◇ In December 2000, the average rent for a two-bedroom apartment in Rhode Island was $715 including heat. This rent is affordable to a full-time, year-round worker earning at least $13.75 per hour or $28,600 per year.[17]

Welfare Reform and Housing Subsidies

◇ As of December 2000 in Rhode Island, 31% (5,032) of households enrolled in the Family Independence Program were receiving housing subsidies.[18]

◇ Welfare reform has a larger positive effect on employment and earnings among families receiving housing subsidies than those who do not receive any assistance with housing.[19]

◇ Housing subsidies may help families obtain and retain employment by stabilizing the lives of low-income families, by freeing up funds within the budgets of low-income families for work-related expenses such as child care, work clothes, and transportation, and by helping families move to areas with greater job opportunities.[20]

Table 4. **Cost of Rental Housing for Low-Income Families, Rhode Island, 2000**

CITY/TOWN	2000 AVERAGE RENT 2-BEDROOM	2000 LOW-INCOME RENTER	% INCOME NEEDED FOR RENT LOW-INCOME RENTER	2000 POVERTY LEVEL FAMILY OF THREE	% INCOME NEEDED FOR RENT POVERTY LEVEL FAMILY OF THREE
Barrington	$966	$19,695	59%	$14,150	82%
Bristol	$698	$19,695	43%	$14,150	59%
Burrillville	$628*	$19,695	38%	$14,150	53%
Central Falls	$564	$19,695	34%	$14,150	48%
Charlestown	NA	$19,695	NA	$14,150	NA
Coventry	$628*	$19,695	38%	$14,150	53%
Cranston	$702	$19,695	43%	$14,150	60%
Cumberland	$845	$19,695	51%	$14,150	72%
East Greenwich	$785	$19,695	48%	$14,150	67%
East Providence	$772	$19,695	47%	$14,150	65%
Exeter	$628*	$19,695	38%	$14,150	53%
Foster	$628*	$19,695	38%	$14,150	53%
Glocester	$628*	$19,695	38%	$14,150	53%
Hopkinton	$628*	$19,695	38%	$14,150	53%
Jamestown	$628*	$19,695	38%	$14,150	53%
Johnston	$665	$19,695	41%	$14,150	56%
Lincoln	$666	$19,695	41%	$14,150	56%
Little Compton	$628*	$19,695	38%	$14,150	53%
Middletown	$872	$19,695	53%	$14,150	74%
Narragansett	$852	$19,695	52%	$14,150	72%
Newport	$1,001	$19,695	61%	$14,150	85%
New Shoreham	$845	$19,695	51%	$14,150	72%
North Kingstown	$833	$19,695	51%	$14,150	71%
North Providence	$727	$19,695	44%	$14,150	62%
North Smithfield	$663	$19,695	40%	$14,150	56%
Pawtucket	$623	$19,695	38%	$14,150	53%
Portsmouth	$891	$19,695	54%	$14,150	76%
Providence	$725	$19,695	44%	$14,150	61%
Richmond	$628*	$19,695	38%	$14,150	53%
Scituate	$628*	$19,695	38%	$14,150	53%
Smithfield	$628*	$19,695	38%	$14,150	53%
South Kingstown	$825	$19,695	50%	$14,150	70%
Tiverton	$715	$19,695	44%	$14,150	61%
Warren	$647	$19,695	39%	$14,150	55%
Warwick	$858	$19,695	52%	$14,150	73%
Westerly	$624	$19,695	38%	$14,150	53%
West Greenwich	NA	$19,695	NA	$14,150	NA
West Warwick	$634	$19,695	39%	$14,150	54%
Woonsocket	$559	$19,695	34%	$14,150	47%
Core Cities	*$694*	*$19,695*	*42%*	*$14,150*	*59%*
Remainder of State	*$719*	*$19,695*	*44%*	*$14,150*	*61%*
Rhode Island	*$715*	*$19,695*	*44%*	*$14,150*	*61%*

Source of Data for Table/Methodology

Rhode Island Housing 2000 Rent Survey, January 2001. A low-income renter is defined as 30% below the 2000 median renter income. Rent burdens over 30% are considered unaffordable. Average rents are based on a survey of rents in Rhode Island in December 2000 and January 2001. Rents include the HUD allowance for heat, if heat was not included in the advertised rent.

*Rhode Island Housing 2000 Rent Survey data are not available for these communities. Average rent used is the Housing and Urban Development (HUD) 2000 Fair Market Rent, as reported in *Out of Reach* (September 2000). Washington, DC: National Low-Income Housing Coalition.

References for Indicator

1,2,3,4,5,6,7 *The State of Rhode Island Consolidated Plan FY 2001 – 2005* (January 2000). Providence, RI: Rhode Island Housing and Mortgage Finance Corporation.

3 *America's Children: Key National Indicators of Well-Being* (2000). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

4,5,6 *Children and Their Housing Needs: A Report to KIDS COUNT* (1993). Washington, DC: Center on Budget and Policy Priorities, and Weissbound, R. (1996). *The Vulnerable Child.* New York: Addison-Wesley Publishing Company.

5 *Not Safe at Home: How America's Housing Crisis Threatens the Health of Children* (February 1998). Boston: The Doc4Kids Project, Boston Medical Center and Children's Hospital.

7 *Changing America: Indicators of Social and Economic Well-Being by Race and Hispanic Origin* (September 1998). Washington, DC: Council of Economic Advisors.

11,12 "Neighborhood Opportunities Program" [Factsheet] (2001). Providence, RI: State of Rhode Island Housing Resources Commission.

13,14 *The State of the Nation's Housing 2000.* (2000). Cambridge, MA: Joint Center for Housing Research, Harvard University.

15,17 Calculations by Rhode Island KIDS COUNT based on data from Rhode Island Housing and the National Low Income Housing Coalition.

16 Rhode Island Department of Human Services, InRhodes Database, December 2000.

18,19 *The Value of Housing Subsidies to Welfare Reform Efforts* (February 2000). Washington, DC: Center on Budget and Policy Priorities.

Secure Parental Employment

DEFINITION

Secure parental employment is the percentage of children living with at least one parent who has full-time, year-round employment.

SIGNIFICANCE

Secure parental employment is a strong determinant of whether or not children will be poor. In 1998 in the U.S., 87% of all non-poor children had at least one parent working full-time, full-year compared to 31% of poor children.[1] Secure parental employment can have positive impacts on child well-being that go beyond reducing poverty and increasing household income. Children with parents who have steady employment are more likely to have access to health care and stable, regular child care.[2]

Secure parental employment is also likely to improve family functioning by reducing the stress brought on by unemployment and underemployment of parents.[3] Many parents who cannot find regular employment end up working at temporary or part-time jobs that do not provide enough money to support a family, that are often at odd hours when formal child care is not available, and that offer little stability.[4]

In 1997, 72% of all children in Rhode Island lived with at least one parent with full-time, year-round employment.[5] Following overall employment trends, the percentage of parents with secure employment nationally increased to 77% in 1998, as compared to 1980 when only 70% of all children lived in families with at least one parent with full-time, full-year employment.[6]

The level of secure parental employment varies significantly by race and ethnicity, family structure, and age of children. Even with sharp increases in the number of single mothers with secure parental employment in the last half of the 1990's, only 44% of single mother families have full-time full-year employment.[7] In comparison, 70% of single father families and 89% of two-parent households had at least one parent securely attached to the labor force.[8] In 1998, 58% of Black, non-Hispanic children and 68% of Hispanic children had a parent working full-time, full-year in contrast to 84% of White, non-Hispanic children.[9] Overall, older children were more likely to live in households with one fully-employed parent than younger children.[10]

Earned Income Tax Credit Benefits Families

◇ The federal Earned Income Tax Credit is a refundable credit on the federal income tax, available since 1975, to low-income and moderate-income working families with children.[11]

◇ 4.7 million people, including 2.6 million children, were lifted above the poverty line as a result of the federal EITC. The EITC removes more children from poverty than any other federal program.[12]

◇ EITC increases the income available to working poor families. The maximum federal benefit available for tax year 2000 was $2,353 for a family with one child and $3,888 for a family with two or more children. The credit phases out gradually as income increases.[13]

◇ The state of Rhode Island is one of fifteen states that have established state EITC programs that help to bring low-wage workers out of poverty. Rhode Island's EITC is non-refundable so it provides no benefits to working families that have income too low to owe state income taxes. In 1999, families in Rhode Island had no state income tax liability until income reached $25,400.[14]

◇ When a state EITC is refundable, the family receives a refund check if the size of its EITC exceeds its tax bill. Refundable EITC programs exist in 10 states and maximize economic benefits to the lowest income families. By providing a supplement to earnings, refundable EITCs can lift families with below-poverty wages to incomes above the federal poverty line.[15]

◇ According to a national study, low-income Hispanic parents are less than half as likely as low-income non-Hispanic parents to know about the Earned Income Tax Credit. Current welfare recipients are less likely than past welfare recipients to know about the program. Outreach to families eligible for the EITC has increased participation nationally.[16]

Working Poor Families

◇ In 1998, 58% of Rhode Island families with incomes below the poverty line worked full-time or part-time, up from 41% in 1993.[17]

◇ Several fundamental changes in the U.S. economy have led to stagnating wages among low-income and middle-income workers. Jobs in the manufacturing sector, which once provided relative prosperity for a broad middle class of unskilled and semi-skilled workers, are being replaced by low-paying service sector jobs.[18]

◇ In Rhode Island between 1988 and 1998, the number of service jobs increased by 39% while the number of manufacturing jobs decreased by 34%.[19] Of Rhode Island working parents with low hourly earnings, 41% work in service jobs, 24% are in retail trade, and 23% are in manufacturing.[20]

◇ Between 1975 and 1997, the poverty rate for young children of college-educated parents remained low at 3%, while the poverty rate among young children of parents with less than a high school diploma increased by 31%.[21]

◇ Low educational attainment and low literacy skills are barriers to finding full-time year-round work with wages that provide income above the poverty level. In 1997 in the U.S., almost two-thirds (63%) of children under age 6 whose parents did not graduate from high school were poor. Almost one-third (29%) of young children whose parents did not have education beyond high school were poor.[22]

Top Three Fastest Growing Jobs, Rhode Island, 1998-2008 (in order of job growth)

	Median Hourly Wage	Median Annual Wage
Retail Salespersons	$8.04	$16,723
Cashiers	$6.73	$13,998
Nursing Aides and Orderlies	$9.12	$18,970

Source: Rhode Island Department of Labor and Training, *Occupational Employment and Wages* (OES). 2001 Edition.

◇ Following the national trend, the three fastest growing jobs in Rhode Island, as predicted by the Bureau of Labor Statistics, pay less than $9.50 per hour. These jobs pay hourly rates that are less than or close to the poverty level for a family of four with one parent working full-time, year-round.[23]

◇ In 1999, 24% of jobs in Rhode Island paid below poverty level for a family of four with one full-time, year-round worker.[24] These working families have incomes that are inadequate to meet the costs of child care, health care, and housing without adequate subsidy systems in place by government and/or employers.[25]

References

[1,4,6,7,9,10] *America's Children: Key National Indicators of Well-Being* (2000). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[2] *Kids Count Data Book* (2000). Baltimore, MD: The Annie E. Casey Foundation.

[3,8] *Trends in the Well-Being of America's Children and Youth* (1999). Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation and Child Trends, Inc.

[11,12,13,14] Johnson, N. (November 2000). *A Hand Up: How State Earned Income Tax Credits Help Working Families Escape Poverty in 2000.* Washington, DC: Center on Budget and Policy Priorities.

[15] Johnson, N. (1999). *A Hand Up: How State Earned Income Tax Credits Help Working Families Escape Poverty.* Washington, DC: Center on Budget and Policy Priorities.

[16] Phillips, K.R. (January 2001). *Who Knows About the Earned Income Tax Credit?* Washington, DC: The Urban Institute.

[17] U.S. Bureau of the Census, Current Population Survey, 1996 to 2000 averages.

[18] Bernstein, J., McNichol, E.C., Mishel, L. et.al. (January 2000). *Pulling Apart: A State-By State Analysis of Income Trends.* Washington, D.C.: Center on Budget and Policy Priorities and the Economic Policy Institute.

[19] Harrington, V.K. (March 1999). *The Rhode Island Economy.* Providence, RI: Rhode Island Economic Development Corporation.

[20] Lazarre, E. (April 1999). *The Poverty Despite Work Handbook.* Washington, DC: Center on Budget and Policy Priorities. "Low Hourly Earnings" is defined as "hourly earnings that on a full-time basis would produce annual earnings below the poverty line for a family of four."

[21,22] *Young Children in Poverty: A Statistical Update.* (1999). New York: National Center for Children in Poverty, Columbia University.

[23] U.S. Bureau of Labor Statistics, calculations by Rhode Island KIDS COUNT.

[24] Mishel, et.al. (2000). *The State of Working America 2000-01.* Washington, DC: Economic Policy Institute.

[25] *The 2000 Rhode Island Standard of Need* (May 2000). Providence, RI: The Poverty Institute, Rhode Island College School of Social Work.

Children Receiving Child Support

DEFINITION

Children receiving child support is the percentage of non-custodial parents in the Rhode Island Child Support Enforcement System who pay child support on time and in full. The percentage does not include cases in which paternity has not been established. Court orders for child support require establishment of paternity.

SIGNIFICANCE

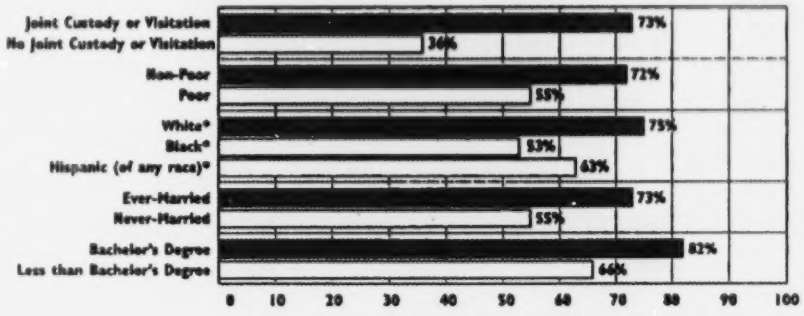
The goal of the child support system is to collect money from non-custodial parents so that their children can have adequate financial security as they grow up. For child support to be collected on behalf of a child, the non-custodial parent must be identified, paternity must be established, a support order must be entered, and the money must be collected.[1] The failure of a non-custodial parent to pay child support has significant economic consequences for the custodial parent and for the child. Nationally, children who live with one parent are nearly four times as likely to be poor as children who live with both parents.[2] In Rhode Island, 31% of all children live in a family with one parent absent.[3]

A child support order may include a provision that the non-custodial parent provide the child's health insurance in addition to cash support. Families who receive health insurance through RIte Care or Medicaid fee-for-service are encouraged to cooperate in establishing paternity and obtaining a child support order, but a child may not be denied health benefits for failure to do so.

Stronger federal and state child support enforcement policies such as wage withholding, in-hospital paternity establishment, and tax intercept programs have resulted in an increased percentage of custodial parents receiving child support payments since the late 1970s.[4] Between 1992 and 1998, federal and state child support enforcement efforts increased collections by 80%.[5] Yet in 1998 in the U.S., just over half (56%) of all custodial parents had awards for financial support from the child's other parent. Of these families, only 41% received all payments they were due.[6]

Even when there is a child support order in place, child support payments tend to be low and unreliable. As of December 2000, there were 90,456 Rhode Island children in the State's Child Support Enforcement System.[7] Of these, 22,302 (25%) have not yet had paternity established and therefore are not yet eligible for a child support award. In 2000 in Rhode Island, only 47% of non-custodial parents under court order paid child support on time and in full. As of December 31, 2000, the amount of past due court-ordered child support in Rhode Island totaled $172 million.[8]

Receipt Rates for Child Support Payments, by Selected Characteristics of Custodial Mother, United States, 1997



Source: Census Bureau (October 2000). *Child Support for Custodial Mothers and Fathers: 1997.* Washington, DC: U.S. Department of Commerce, Economics and Statistics Administration. All data are for custodial mothers only.
*Data for other race/ethnic groups are not available.

◇ Parents who have regular contact with their children are more likely to pay child support. In 1997 in the United States, 73% of parents who had either joint custody or visitation privileges paid child support compared to 36% who did not have regular contact.[9]

◇ Of parents due child support in 1997, the percentage of custodial parents with incomes below the poverty line who received child support payments was 55%, compared to 72% of non-poor parents.[10]

◇ Low-income mothers, Black or Hispanic mothers, never-married mothers, and mothers with less than a college education are least likely to receive the child support due under court order.[11]

Child Support Enforcement and Non-Custodial Parents

◇ Many non-custodial parents would like to support their children financially but are poor themselves, lack job experience, and have limited education.[12,13] Child support is more likely to be paid when enforcement strategies are combined with job training, job retention support, and transportation assistance for the non-custodial parent.[14]

◇ The U.S. Department of Health and Human Services Fatherhood Initiative encourages states to improve work opportunities for low-income fathers, increase child support collections, provide programs to enhance parenting skills, support access and visitation by non-custodial parents, reduce domestic violence, and involve boys and young men in preventing teenage pregnancy and early parenthood.[15]

◇ In an effort to encourage greater use of child support services by non-custodial parents, the law in Rhode Island has recently changed so that child support enforcement attorneys no longer represent the custodial parent but now represent the State of Rhode Island.[16] A non-custodial parent who has no ability to pay child support due to unemployment is now eligible for participation in employment training and referral programs.[17]

Child Support and the Family Independence Program

◇ In order to receive cash benefits through the Family Independence Program, custodial parents are required to cooperate with the Rhode Island Department of Administration's Child Support Enforcement Division in establishing paternity and seeking child support.

◇ In certain instances, such as where there has been domestic violence, the requirement to establish paternity and seek child support may be waived in order to protect the custodial parent. Caseworkers are required to notify FIP applicants and recipients of this waiver option.[18]

◇ As of December 2000 in Rhode Island, 81% (25,037) of the 30,870 children enrolled in the Family Independence Program were in the Child Support Enforcement System. Of these, just over half (17,519) have paternity established.[19]

◇ The average child support obligation to children enrolled in FIP is $244 per month, as compared to an average child support obligation of $260 per month for non-FIP families.[20]

◇ Rhode Island has maintained a $50 pass-through for families in the Family Independence Program. The first $50 of child support paid on behalf of a child receiving cash assistance goes to the custodial parent caring for the child. The pass through occurs only if child support payments are received on-time and in-full.[21]

References for Indicator

[1] *Giving Hope and Support to America's Children: Handbook on Child Support Enforcement.* Washington, DC: U.S. Department of Human Services, Administration for Children and Families Office of Child Support Enforcement.

[2] Sorenson, E. and Zibman, C., (March 2000). *Child Support Offers Some Protection Against Poverty.* Washington, DC: The Urban Institute.

[3] U.S. Bureau of the Census, Current Population Survey, 1996 to 2000 average.

[4] Sorenson, E. and Zibman, C. (April 1999). *Child Support Enforcement is Working Better Than We Think.* Washington, DC: The Urban Institute.

[5,6] *Economic Report of the President* (2000). Washington, DC: U.S. Council of Economic Advisors.

[7,8,9,10] *Child Support for Custodial Mothers and Fathers: 1997* (October 2000). Washington, DC: U.S. Census Bureau.

[11,12,13,18] Rhode Island Department of Administration, Division of Taxation – Child Support Enforcement, December 2000. Also see methodology on page 111.

[14] Sorenson, E. and Zibman, C., (September 2000). *A Look At Poor Dads Who Don't Pay Child Support.* Washington, DC: The Urban Institute.

[15,16] *Map and Track: State Initiatives to Encourage Responsible Fatherhood* (1999). New York, NY: National Center for Children in Poverty, Columbia University.

[17] U.S. Department of Health and Human Services, Fatherhood Initiative Website http//fatherhood.hhs.gov/ (January 2001).

[19] *Paternity: Questions Moms Usually Ask and Their Answers.* Providence, RI: State of Rhode Island and Providence Plantations.

[20] Rhode Island Department of Human Services, January 2001.

Children in Poverty

DEFINITION

Children in poverty is the percentage of related children under age 18 who live in families below the poverty threshold, as defined by the U.S. Office of Management and Budget. "Related children" include the family head's children by birth, marriage and adoption, as well as other persons under age 18 who are related to and live with the family head, such as nieces and nephews.

SIGNIFICANCE

Children most at risk of not achieving their full potential are children in poverty, regardless of race.[1] Poverty is related to every KIDS COUNT indicator. Young children who are born in poor families are more likely to experience poor health and to die during childhood. In school they are more likely to score lower on standardized tests, to repeat a grade and to drop out. As teenagers they are less likely to avoid out-of-wedlock births and violent crime. As adults they are more likely to be poor.[2] Children in low-income communities are more likely to attend poorly equipped schools; have less access to libraries and cultural activities; have limited access to high quality child care programs; and have fewer opportunities to participate in sports and recreations programs after school and in the summer.[3,4]

Single parenthood, low educational attainment, part-time or no employment and low wages of parents place children at risk of being poor.[5] Family economic conditions in early and middle childhood appear to be more important for shaping ability and achievement than do economic conditions during adolescence.[6] Efforts that improve the quality of a child's environment, especially in the early years of life, can produce lifelong impacts on learning, social skills, and mental health.[7]

Over time, many more people are poor than the official poverty line suggests. There is considerable movement into and out of poverty each year.[8] Those living with incomes close to the poverty line are vulnerable to falling into poverty due to changes in employment, housing and utility costs, life changes such as the birth of a child, changes in marital status and illness or disability.[9] In 2000, the official poverty level for a family of four was $17,050. This is just over one-third of the median family income for Rhode Island families with children.[10]

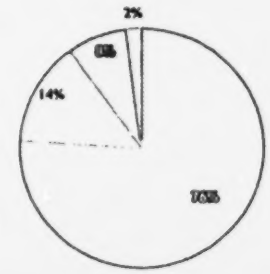
Rhode Island's Poor Children, 1998

By Age

36%	Ages 5 and younger
36%	Ages 6 to 11
28%	Ages 12 to 17

By Race*

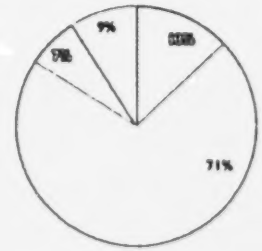
76%	White
14%	Black
8%	Asian
2%	American Indian



**Hispanic children may be included in any race category. Of Rhode Island's 40,231 poor children, 30% are Hispanic.*

By Family Structure

13%	Two Parents
71%	Mother Only
7%	Father Only
9%	Other



◇ In 1998, there were 40,231 poor children in Rhode Island, 18% of all Rhode Island children. This is higher than the 1990 Census figure when 30,022 (14%) of the state's children lived in poverty.

Source: U.S. Bureau of the Census, Current Population Survey, 1996 to 2000 average.

Young Children Under Age 6 in Poverty in Rhode Island

◇ In 1998, 36% of Rhode Island's poor children were under age 6. Nearly one in five Rhode Island children under age 6 was living in poverty.[11]

◇ As of December 1, 2000 there were 12,128 young children under age 6 in families receiving cash assistance through the Family Independence Program. Of all children in the Family Independence Program, 39% are under age 6.[12]

◇ Poor children under age 6 are much more likely to live in families receiving cash assistance than older children in poor families. As of December 2000 in Rhode Island, 85% of poor children under age 6 were receiving cash assistance as compared to 77% of poor children ages 6 to 11 and 66% of poor children ages 12 to 18.[13]

◇ Research shows that the quality of a child's environment and social interactions in the early years affect brain development, producing lifelong impacts on learning, social skills and mental health.[14]

◇ Young children born into poverty are more likely to...
- be born low birthweight;
- die in infancy or early childhood;
- receive lower quality medical care;
- experience hunger and malnutrition;
- be victims of or witnesses to violence;
- be exposed to environmental toxins.[15]

Children Living in Extreme Poverty

◇ Families with income below 50% of the federal poverty level are considered to be living in extreme poverty. The extreme poverty level in 2000 was family income below $8,525 for a family of four.[16]

◇ Nationally, the number of U.S. children living in extreme poverty has increased from 5% in 1975 to 8% in 1997.[17]

◇ In 1997, there were 23,370 Rhode Island children living in extreme poverty. This is 10% of all Rhode Island children and more than half of all poor children in Rhode Island.[18]

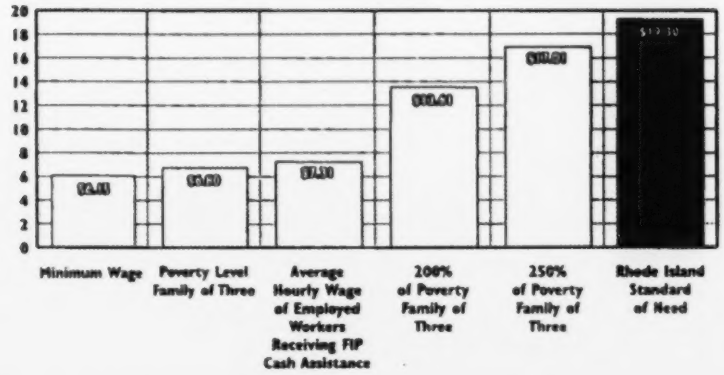
◇ Young children and children of color are more likely to live in extreme poverty. In the U.S., one in ten children under age 6 is extremely poor.[19] Almost one-in-five (17%) Black children, 13% of Hispanic children, and 4% of White, non-Hispanic children live in extreme poverty.[20]

◇ While the overall child poverty rate has declined nationally in recent years, on average those who remain poor have become poorer. After taking into account the value of non-cash benefits and the Earned Income Tax Credit, the average income of a person living in poverty fell $2,416 below the poverty line in 1999 in contrast to $2,104 in 1993.[21]

◇ Children who live in poverty for multiple years and children who live in extreme poverty experience the worst outcomes as a result of their family's income status.[22] Programs that raise the income of poor families are likely to enhance the cognitive development of children and improve their chance of success in the labor market in adulthood.[23]

Children in Poverty

Wages Compared to the Standard of Need, Rhode Island, 2000



Source: *The 2000 Rhode Island Standard of Need* (2000). Providence, RI: The Poverty Institute, Rhode Island College School of Social Work.

◇ The official poverty level is an underestimate of the number of families who are unable to meet basic living expenses. Many researchers are critical of the measure used by the federal government to measure poverty because it does not take into account costs for housing, child care, and health care.[34]

◇ The Rhode Island Standard of Need more closely approximates the income a family needs to pay for basic living expenses. The Standard of Need is defined as the hourly wage that a single parent with two children needs to adequately provide for the family's basic living expenses. The 2000 Rhode Island Standard of Need is $19.30 per hour or $2,941 per month.[35]

◇ RIte Care, child care subsidies, the FIP Earned Income Disregard, Food Stamps, public housing, and the Earned Income Tax Credit are important policies to ensure that low-income working families have adequate resources to meet their basic needs.[36]

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Building Blocks of Economic Security

Educational Attainment

◇ Individuals with higher education generally have more job opportunities, higher wages and greater job security than those with lower levels of education.[37]

High Quality Child Care

◇ The quality and stability of the child care setting is critical to a parent's ability to work and to the child's development.[38]

Affordable Housing

◇ Stable housing is a critical requirement for job retention and performance. Low-income adults with unstable housing situations are less likely to find and keep a job.[39]

Family Income Levels Based on the Federal Poverty Guidelines

Many federal programs use the federal poverty guidelines to determine whether or not families are eligible for services. Often, government assistance programs, including many of those administered by the state of Rhode Island, use 185% to 250% of the federal poverty line to determine income eligibility. The figures are adjusted upward for larger family sizes.

2000 Federal Poverty Level (FPL)	Annual Income Family of Three	Annual Income Family of Four
50% FPL	$7,075	$ 8,525
100% FPL	$14,150	$17,050
130% FPL	$18,395	$22,165
185% FPL	$26,178	$31,543
200% FPL	$28,300	$34,100
225% FPL	$31,838	$38,363
250% FPL	$35,375	$42,625

Source: 2000 Federal Poverty Guidelines issued by the U.S. Department of Health and Human Services.

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Table 5.

Child Poverty, Rhode Island, 1990

CITY/TOWN	FAMILIES WITH CHILDREN BELOW POVERTY		CHILDREN UNDER 18 BELOW POVERTY		CHILDREN UNDER 6 BELOW POVERTY	
	N	%	N	%	N	%
Barrington	27	1.3%	52	1.3%	33	2.6%
Bristol	108	4.5%	253	5.9%	128	8.3%
Burrillville	148	6.3%	276	6.1%	119	8.5%
Central Falls	710	28.5%	1,576	32.5%	749	38.0%
Charlestown	68	7.8%	145	9.4%	39	6.4%
Coventry	199	4.7%	402	5.3%	180	7.3%
Cranston	735	8.9%	1,378	9.5%	562	10.9%
Cumberland	145	4.0%	302	4.7%	151	7.4%
East Greenwich	75	4.6%	153	5.3%	112	13.0%
East Providence	499	8.0%	904	8.7%	353	9.9%
Exeter	26	3.3%	52	3.6%	5	1.0%
Foster	34	5.5%	88	7.6%	0	0.0%
Glocester	99	7.2%	156	6.5%	77	10.0%
Hopkinton	40	4.1%	75	4.1%	9	1.4%
Jamestown	59	8.9%	92	8.1%	45	11.9%
Johnston	266	9.0%	452	8.4%	187	10.6%
Lincoln	164	7.2%	272	7.0%	98	7.2%
Little Compton	12	2.6%	20	2.7%	15	5.1%
Middletown	129	5.1%	275	6.0%	158	9.1%
Narragansett	71	4.4%	122	4.5%	36	3.6%
Newport	559	17.7%	1,143	20.3%	575	27.0%
New Shoreham	12	12.4%	17	10.1%	6	10.0%
North Kingstown	185	5.4%	281	4.7%	121	6.1%
North Providence	184	5.6%	298	5.4%	78	4.3%
North Smithfield	23	1.7%	37	1.6%	19	3.1%
Pawtucket	1,255	13.4%	2,525	15.5%	1,096	17.3%
Portsmouth	95	3.8%	182	4.4%	70	5.2%
Providence	5,621	29.2%	12,946	34.5%	5,531	36.8%
Richmond	9	1.1%	30	2.0%	0	0.0%
Scituate	45	3.3%	91	3.7%	19	2.3%
Smithfield	75	3.4%	155	4.1%	61	4.9%
South Kingstown	134	4.9%	350	7.5%	133	8.7%
Tiverton	109	6.0%	200	6.4%	81	7.9%
Warren	132	9.3%	199	8.5%	56	6.2%
Warwick	519	5.1%	1,084	5.9%	448	7.2%
Westerly	210	7.3%	432	8.7%	224	12.9%
West Greenwich	14	2.9%	26	2.9%	11	4.2%
West Warwick	395	10.7%	746	11.8%	291	13.0%
Woonsocket	1,183	20.0%	2,235	21.4%	1,034	26.9%
Core Cities	*9,328*	*23.2%*	*20,425*	*27.3%*	*8,985*	*30.7%*
Remainder of State	*5,043*	*6.0%*	*9,597*	*6.5%*	*3,927*	*7.9%*
Rhode Island	*14,371*	*11.6%*	*30,022*	*13.5%*	*12,912*	*16.3%*

Source: U.S. Bureau of the Census, 1990 Census of Population.

References for Indicator

[1] Children's Defense Fund. (1994). *Wasting America's Future: The Children's Defense Fund Report on the Costs of Child Poverty in America.* Boston: Beacon Press.

[2,11] "Children and Poverty: Analysis and Recommendations" in *The Future of Children: Children in Poverty* (1997). Los Altos, CA: Center for the Future of Children.

[3,28] *Years of Promise: A Comprehensive Strategy for America's Children* (1996). New York, NY: Carnegie Corporation.

[4] Jargowsky, P. (1997) *Poverty and Place: Ghettos, Barrios and the American City.* New York, NY: Russell Sage Foundation.

[5,6,7] *Young Children in Poverty: A Statistical Update* (June 1999). New York, NY: National Center for Children in Poverty.

[8] Duncan G.J. and Moscow I. (1997). "Longitudinal Indicators of Children's Poverty and Dependence" in Hauser, R. et. al. (eds.) *Indicators of Children's Well-Being.* New York, NY: Russell Sage Foundation.

[9,10] *One in Four* (1996). New York, NY: National Center for Children in Poverty, Columbia University.

[12] O'Hare, W.P. (September 1996). " A New Look at Poverty in America" in *Population Bulletin, Vol.51.* Washington, DC: The Population Reference Bureau.

[13] *The 2000 HHS Poverty Guidelines* (2000). Washington, DC: U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation.

[14,15] US Bureau of the Census, Current Population Survey, 1996 to 2000 average.

[16,18] Rhode Island Department of Human Services. InRhodes Database, December 2000.

[17] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York, NY: Carnegie Corporation; and Shore, R. (1997). *Rethinking the Brain.* New York, NY: Families and Work Institute.

[19,20] *Kids Count Data Book* (2000). Baltimore, MD: The Annie E. Casey Foundation.

[21] *Trends in the Well-Being of America's Children and Youth* (2000). Washington, DC: U.S. Department of Health and Human Services.

[22] *America's Children: Key Indicators of Well Being* (2000). Washington, DC: U.S. Bureau of the Census.

[23] *Poverty Rate Hits Lowest Level Since 1979 As Unemployment Reaches a 30-Year Low* (October 2000). Washington, DC: Center on Budget and Policy Priorities.

[24] Duncan, G. and Brooks-Gunn, J. eds. (1997). *Consequences of Growing Up Poor.* New York, NY: Russell Sage Foundation.

[25,26] *The 2000 Rhode Island Standard of Need* (2000). Providence, RI: The Poverty Institute, at Rhode Island College School of Social Work.

[27] *The Value of Housing Subsidies to Welfare Reform Efforts* (February 2000). Washington, DC: Center on Budget and Policy Priorities.

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Children in the Family Independence Program

DEFINITION

Children enrolled in the Family Independence Program is the percentage of children less than age 18 who were living in families receiving cash assistance through the Family Independence Program (FIP) on December 1, 2000. These data measure the number of children and families enrolled in FIP at one point in time. They do not count the additional children and families who qualified for the program at other points in the year but were not enrolled on December 1, 2000.

SIGNIFICANCE

Rhode Island's Family Independence Program seeks to help families make successful transitions to work by providing the supports, including health insurance and subsidized child care, that families need to obtain and keep a job. The Family Independence Program allows two-parent and single-parent families to obtain cash assistance. The program provides work incentives by allowing working recipients to keep more of their earnings before cash assistance is decreased or terminated.

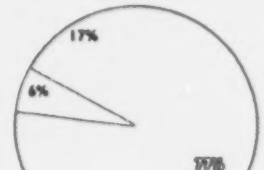
If a family has no earned income, the maximum FIP benefit for a Rhode Island family of three is $554 per month. With an additional $305 per month in Food Stamps, the monthly combined benefit is $859.[1] This amount is 73% of the federal poverty level. While cash benefits alone do not lift families out of poverty, they provide minimal subsistence for poor families. When combined with earned income and the Earned Income Tax Credit, cash assistance can move a family working full-time at minimum wage above the federal poverty line of $14,150 for a family of three. As of December 1, 2000 in Rhode Island, 25% of the 14,611 adults receiving FIP cash assistance were employed.[2] The average wage for employed FIP recipients is $7.31 per hour.[3]

Through FIP, children in families that are income-eligible are entitled to cash assistance without time limits. A five-year lifetime limit for cash benefits is placed on adults in the family. Two-thirds of all FIP beneficiaries are children under the age of 18. More than 80% of all children receiving cash assistance through FIP are ages 12 and under.[4] As of December 1, 2000, there were 30,870 Rhode Island children in families receiving cash assistance through the Family Independence Program. In the core cities as a whole (Providence, Pawtucket, Central Falls, Woonsocket and Newport), 32% of children live in families that receive cash assistance through FIP compared to 5% of children in the remainder of the state.[5]

Families Enrolled in the Family Independence Program, December 2000

By Family Type

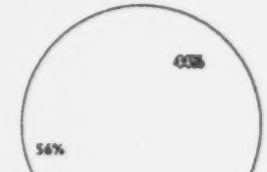
77%	Single Parents
6%	Two-Parents
17%	Child Only



n = 16,229

By Participation in Work/ Education/Training

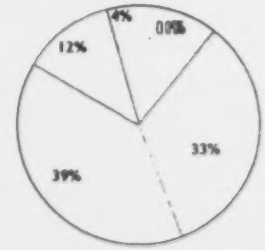
44%	Participating
56%	Not Participating



n = 11,209
(Includes all adults with work requirements and FIP employment plans.)

By Education Level of Household Head

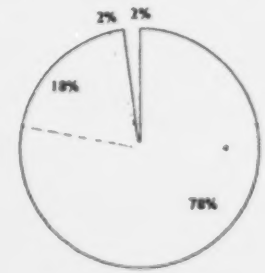
11%	Less than 9th grade
33%	Grades 9 to 11
39%	High School Graduate
12%	Some College or College Graduate
4%	Not Reported



n = 13,178
(Does not include the child only cases)

By Primary Language

78%	English
18%	Spanish
2%	Asian
2%	Other



n = 16,229
"Asian" includes Vietnamese, Cambodian, Laotian, Hmong.
"Other" includes Portuguese, French, Polish, Italian, Hungarian, Russian.

Source: Rhode Island Department of Human Services, INRHODES Database, December 2000.

The Rhode Island Family Independence Program

Under the federal welfare reform law that replaced AFDC with the Temporary Assistance for Needy Families program (TANF), states are allowed to develop their own supports programs for needy families. The Family Independence Program is Rhode Island's welfare reform program as set forth in the Rhode Island Family Independence Act of 1996.

◇ Single parent and two-parent families are eligible for cash assistance if they meet the income eligibility guidelines (approximately 110% to 115% of the poverty line). Working cash recipients can earn up to $170 monthly without a reduction in cash assistance amount. After the first $170, benefits are reduced $1 for every $2 earned.

◇ There is a five-year lifetime limit on receipt of cash assistance by adults unless they are working at least 30 hours per week or receive an exemption; cash assistance to eligible children is without time limits. Eligible teen parents under age 18 must live at home or in a supervised setting and stay in school.

◇ Unless exempt from the work requirements, adult recipients must develop an employment plan with a FIP social worker. There were 11,209 adults recipients with a signed employment plan as of December 2000.[6] The employment plan identifies the training, education, work readiness, or work in which the recipient will participate.

◇ There are approximately 3,690 adults who are exempt from the work requirement for one or more of the following reasons: child under age one (2,013), head of household under age 18 (80), third trimester pregnancy (401), illness or incapacity (399), illness or incapacity of a spouse or child (62), head of household age 60 or over (34), other (701).[7]

Welfare Reform and Children in Vulnerable Families

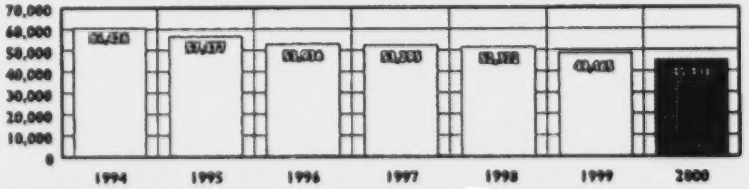
◇ National welfare research indicates that families receiving sanctions (i.e. losing cash benefits for non-compliance with program guidelines) are more likely to have prior contacts with child welfare agencies or protective services.

◇ Parents who have received welfare for two or more years are likely to have children who are already at particularly high developmental risk. As welfare reform is implemented, it is crucial that these children receive assessments and early intervention for developmental issues, are enrolled in high quality child care, and have a regular source of health care.

◇ Some families will need a variety of social supports and social services in order to successfully transition from welfare to work. Comprehensive programs help parents find and keep employment, address the health and developmental needs of their children, strengthen parent-child relationships, and assist families with individual challenges. Many families will need assistance with housing, transportation, substance abuse, domestic violence, and other issues in order to make a successful transition.[8,9]

Source: Research Forum on Children, Families, and the New Federalism (July 1999). *Children in Fragile Families Face Multiple Risks under Welfare Reform.* New York, NY: National Center for Children in Poverty, Columbia University School of Public Health.

Adults and Children Enrolled in AFDC/Family Independence Program, 1994 to 2000



Source: Rhode Island Department of Human Services, INRHODES Database, 1994 to 2000.

Note: Prior to May 1, 1997, the Family Independence Program was AFDC (Aid to Families with Dependent Children). Two-thirds of FIP recipients are children under age 18.

Children in the Family Independence Program

Elements of Effective Welfare Reform

Assists families in obtaining sustainable jobs that move them out of poverty and into economic self-sufficiency.

◇ Low-income working families require adequate income to meet their needs for housing, food, clothing, health insurance, child care, and transportation. Entry into sustainable jobs at a sufficient wage requires assistance with job placement, job training, English-language programs, literacy programs, vocational education, and post-secondary education.[10]

◇ Since the beginning of the Family Independence Program, the proportion of the FIP caseload with adults working has increased from 14% in April 1997 to 25% in December 2000.[11]

Income Levels of FIP Families, by Work Status

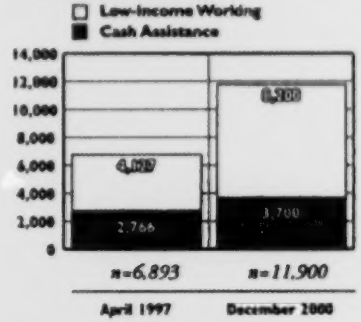
Family of 3 Not Working	Per Month	Family of 3 Working	Per Month
Cash Assistance	$554	Wages (30 hrs at $6.15/hr)	$799
Food Stamps	$305	Cash Assistance	$239
Income	*$859*	EITC	$319
		Food Stamps	$221
		FICA	($61)
		Income	*$1,517*

◇ A family of three enrolled in FIP and working 30 hours per week at minimum wage has an income of $1,517 per month, 129% of the federal poverty level. A family of 3 enrolled in FIP and not working has an income of $859 per month, 73% of the federal poverty level.

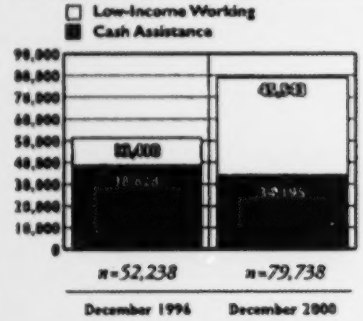
Source: Rhode Island Department of Human Services, December 2000. EITC is the Earned Income Tax Credit and FICA is federal income tax.

Supports the healthy development of children and provides access to a range of supports needed by low-income families.

Families Receiving Child Care Subsidies



Children Enrolled in Medical Assistance (RIte Care, Medicaid)



Source: RI Department of Human Services InRhodes Database and the Center for Child and Family Health. Medical Assistance includes RIte Care and Medicaid Fee-for-Service.

◇ The Rhode Island Family Independence Program seeks to support the healthy development of children by providing high quality affordable child care and health insurance to low-income working families.

◇ Since the implementation of FIP, low-income working families have accounted for the largest increases in participation in RIte Care health insurance and child care subsidy programs.[12]

◇ Access to affordable health insurance and affordable child care is critical to a parent's ability to work and to healthy child development.[13,14] Lack of affordable health insurance results in days lost from work and school. National studies show that among mothers of all income levels, higher cost child care is associated with a higher probability of refusing or terminating employment.[15]

Table 6.

Children Enrolled in the Family Independence Program (FIP), Rhode Island, December 1, 2000

CITY/TOWN	CHILDREN UNDER 18	NUMBER RECEIVING FIP CASH ASSISTANCE		FIP CHILDREN AS % OF ALL CHILDREN UNDER 18
		FAMILIES	CHILDREN	
Barrington	3,896	23	32	1%
Bristol	4,317	116	189	4%
Burrillville	4,215	68	117	3%
Central Falls	4,603	852	1,723	37%
Charlestown	1,795	32	53	3%
Coventry	7,682	181	262	3%
Cranston	14,079	769	1,291	9%
Cumberland	6,338	100	167	3%
East Greenwich	2,653	52	79	3%
East Providence	10,351	432	764	7%
Exeter	1,672	15	22	1%
Foster	1,175	16	24	2%
Glocester	2,257	31	59	3%
Hopkinton	2,035	32	43	2%
Jamestown	1,228	10	13	1%
Johnston	5,294	247	398	8%
Lincoln	3,918	98	226	6%
Little Compton	701	6	8	1%
Middletown	4,487	70	97	2%
Narragansett	3,206	64	94	3%
Newport	5,437	494	1010	19%
New Shoreham	178	2	3	2%
North Kingstown	6,809	161	286	4%
North Providence	5,641	278	457	8%
North Smithfield	2,088	21	32	2%
Pawtucket	16,093	1,854	3,371	21%
Portsmouth	4,387	42	64	1%
Providence	37,195	7,376	15,077	41%
Richmond	1,610	37	60	4%
Scituate	2,635	20	29	1%
Smithfield	3,958	49	79	2%
South Kingstown	5,152	107	204	4%
Tiverton	2,988	68	99	3%
Warren	2,487	81	166	7%
Warwick	18,811	571	919	5%
Westerly	5,666	185	317	6%
West Greenwich	1,147	18	26	2%
West Warwick	6,696	409	698	10%
Woonsocket	10,101	1,242	2,376	24%
Core Cities	*73,429*	*11,818*	*23,557*	*32%*
Remainder of State	*151,552*	*4,411*	*7,313*	*5%*
Rhode Island	*224,981*	*16,229*	*30,870*	*14%*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, INRHODES Database, December 2000.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The denominator is the total number of children under age 18 in 1999 according to Geolytic estimates using data from the U.S. Bureau of the Census, 1990 Census of Population.

See methodology on page 110 for additional information on Geolytic estimates.

References for Indicator

[1,3,4,6,7] Rhode Island Department of Human Services, INRHODES Database, December 1, 2000.

[2] Rhode Island Department of Human Services, INRHODES Database, December 1, 2000. Calculations by Rhode Island KIDS COUNT.

[4,5] Cauthen, N.K., Knitzer, J. (1999). *Children and Welfare Reform, Issue Brief #6. Beyond Work: Strategies to Promote the Well-Being of Young Children and Their Families.* New York, NY: National Center for Children in Poverty.

[5,8] *Windows of Opportunity: Strategies to Support Families Receiving Welfare and Other Low-Income Families in the Next Stage of Welfare Reform* (January 2000). Washington, DC: Center on Budget and Policy Priorities.

[11,12] Rhode Island Department of Human Services, INRHODES Database, April 1997 and December 2000.

[10] Collins, A., Jones, S., Bloom, H. (1996). *Children and Welfare Reform: Highlights from Recent Research.* New York: National Center for Children in Poverty, Columbia University School of Public Health.

[11] *Access to Child Care for Low-Income Working Families* (1999). Washington, DC: U.S. Department of Health and Human Services.

Children Receiving Food Stamps

DEFINITION

Children receiving food stamps is the percentage of income-eligible children under age 18 who participate in the Food Stamp program.

SIGNIFICANCE

The Food Stamp program provides monthly benefits to low-income households for the purchase of food at retail stores. The Food Stamp program provides important nutrition benefits to low-income families who would otherwise be at high risk for undernutrition and poor health.[1]

To qualify for Food Stamps, a household's gross income must be less than 130% of the federal poverty level for that family size and meet requirements that limit the value of assets (such as cash and automobiles). For example, a family of four with an annual income less than $22,165 (monthly income less than $1,847) will qualify for Food Stamps if they meet the asset guidelines. Many of Rhode Island's documented immigrants qualify for food stamp benefits. Rhode Island is one of 13 states that has state-funded food stamps for some immigrants who are no longer eligible for federally-funded food stamps.[2]

The Food Stamp program is an entitlement, meaning that federal funding is provided to all applicants who meet the eligibility requirements. One of the strengths of the Food Stamp program is its flexibility. The program is structured to respond to changes in need brought on by economic cycles or natural emergencies.[3] The benefit level for each eligible household is adjusted according to income. The monthly benefit level decreases as household income increases.

The maximum monthly Food Stamp benefit for a Rhode Island family of three is $341. The average monthly benefit for family of three in the state is $203, a decrease from the 1997 monthly average of $270.[4] As of December 1, 2000 there were 38,557 children in Rhode Island who received benefits from the Food Stamp program. More than half (54%) of all food stamp recipients in Rhode Island are children under age 18.[5] Nationally households with children receive 80% of all food stamp benefits.[6]

In Rhode Island in 1998, between 62% and 78% of all Rhode Islanders eligible for the Food Stamp program were enrolled.[7] As the number of families using the Food Stamp program has decreased, food pantries and emergency food banks have seen their service numbers rise. The Rhode Island Community Food Bank reported a 98% increase in the quantity of food that they distribute since 1996.[8]

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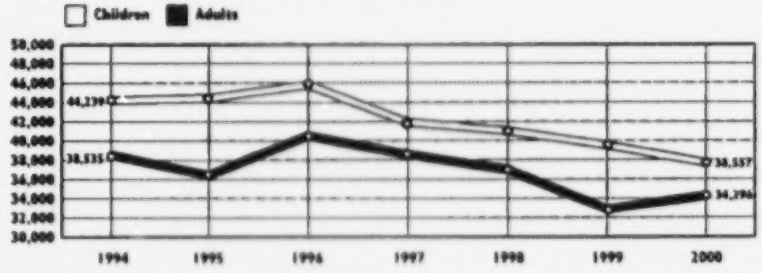
Food Stamp Participation, Children under Age 18 and Adults, Rhode Island, 1994-2000



Source: RI Department of Human Services, INRHODES Database, 1994-2000.

◇ Between 1994 and 2000, participation in the Food Stamp program decreased by 11% for Rhode Island adults and by 15% for Rhode Island children. Just over half (51%) of income eligible children were enrolled in the Food Stamp program as of December 2000.[9]

Hunger and Food Insecurity

◇ In 1999 in the U.S., there were about 12 million children living in households that were experiencing food insecurity – defined by the USDA as households that do not have access to enough food to meet basic needs at all times during the year.[10]

◇ The Food Stamp program is the central component of U.S. national policy to reduce hunger and food insecurity. Yet, in 1998 only 59% of those eligible for Food Stamps in the U.S. were enrolled. This is a decrease from 1994 when 71% of those eligible were enrolled.[11]

◇ Only a portion of the declines in national Food Stamp program participation in recent years can be attributed to the strong economy and low unemployment rates. Two-thirds of all U.S. families that have left the Food Stamp program were still eligible.[12]

◇ Lack of client information about eligibility is a barrier to participation. Among non-participating persons eligible for Food Stamp benefits surveyed in 1996, nearly three-quarters (72%) were not aware that they were eligible.[13]

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Table 7. **Children Under Age 18 Receiving Food Stamps, Rhode Island, December 1, 2000**

CITY/TOWN	ESTIMATED NUMBER INCOME-ELIGIBLE	NUMBER PARTICIPATING	% OF INCOME-ELIGIBLE PARTICIPATING
Barrington	48	29	60%
Bristol	NA	252	NA
Burrillville	466	199	43%
Central Falls	5,298	2,209	42%
Charlestown	NA	67	NA
Coventry	738	330	45%
Cranston	2,472	1,556	63%
Cumberland	609	224	37%
East Greenwich	115	98	85%
East Providence	2,691	1,033	38%
Exeter	NA	30	NA
Foster	107	28	26%
Glocester	299	87	29%
Hopkinton	NA	85	NA
Jamestown	54	12	22%
Johnston	878	543	62%
Lincoln	377	204	54%
Little Compton	40	13	33%
Middletown	671	135	20%
Narragansett	308	105	34%
Newport	2,585	1,263	49%
New Shoreham	17	3	18%
North Kingstown	540	375	69%
North Providence	1,036	547	53%
North Smithfield	132	40	30%
Pawtucket	9,826	4,307	44%
Portsmouth	179	84	47%
Providence	34,668	18,549	54%
Richmond	NA	96	NA
Scituate	145	35	24%
Smithfield	174	106	61%
South Kingstown	424	244	58%
Tiverton	266	122	46%
Warren	NA	234	NA
Warwick	2,421	1,146	47%
Westerly	722	433	60%
West Greenwich	NA	39	NA
West Warwick	2,031	876	43%
Woonsocket	5,687	2,819	50%
Core Cities	*58,784*	*29,147*	*50%*
Remainder of State	*18,918*	*9,410*	*50%*
Rhode Island	*75,403*	*38,557*	*51%*

Source of Data for Table/Methodology

Estimated number income-eligible is based on the total number of children ages birth to 18 (projections from the 1990 Census) multiplied by the % of students eligible for free School Lunch in each community. Families with incomes less than 130% of poverty are income-eligible for free School Lunch and for Food Stamps. The Food Stamp program also has an assets limitation as part of eligibility determination. Free lunch percentages are from the Rhode Island Department of Education, October 1999.

NA: Numbers are not available as community has a regional school district.

Food Stamp program participation data are from the Rhode Island Department of Human Services, INRHODES Database, December 1, 2000. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

References for Indicator

[1] Cook, J.T. (May 1998). "The Importance of the Food Stamp Program for Low-Income Legal Immigrants." Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

[2] *State Government Responses to The Food Assistance Gap* (2000). Washington, DC: Food Research and Action Center and America's Second Harvest.

[3,4] *Federal Food Programs: Food Stamp Program Frequently Asked Questions.* Food Research and Action Center website: www.frac.org (January 2001).

[4,5,6] Rhode Island Department of Human Services, INRHODES Database, December 1, 1994-2000. Calculations by Rhode Island KIDS COUNT.

[7,11] Schirm, A. (January 2001). *Reaching Those In Need: State Food Stamp Participation Rates in 1998.* Princeton, NJ: Mathematica Policy Research, Inc.

[8] Rhode Island Community Food Bank (2000). Administrative Databases and [Fact Sheet] *Helping Ourselves to Help Our Community – Accessing Food Stamps.*

[9,10] Andrews, M. et. al. (2000). *Household Food Insecurity in the US, 1999.* Washington, DC: U.S. Department of Agriculture.

[12,13] "Food Stamp Participation Drops by Over 7 Million from November 1996 to November 2000" (2000). Washington, DC: Food Research and Action Center.

Children Receiving School Breakfast

DEFINITION

Children receiving school breakfast is the percentage of low-income public school children who attend schools offering the School Breakfast Program. Children are counted as low-income if they are eligible for and enrolled in free or reduced price lunch.

SIGNIFICANCE

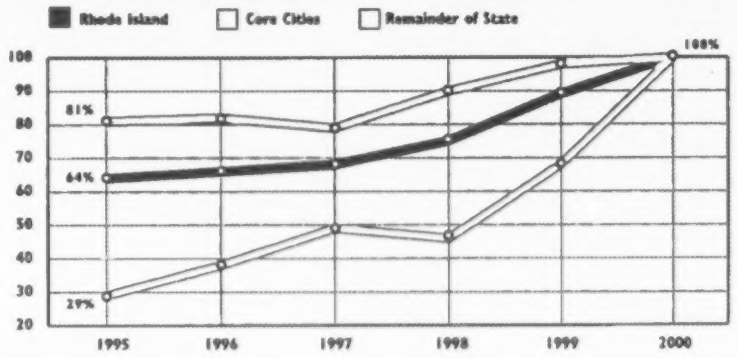
Undernutrition during any period of childhood can have a detrimental impact on a child's cognitive development. The longer a child's nutritional needs go unmet, the greater the risk of cognitive impairment.[1] Low-income students are more likely than other students to arrive at school without an adequate breakfast.[2] The School Breakfast Program offers nutritious meals to children at participating schools, providing children with one-fourth or more of their Recommended Daily Allowance for key nutrients.[3]

Many children need access to the School Breakfast Program because their parents cannot afford to make sure they receive nutritious breakfasts each day. In 1999, there were about 12 million children in the country that did not have access to enough food to meet basic needs at all times during the year.[4] For others, long commute times and rushed family schedules make having time for eating breakfast before school difficult and put children at a disadvantage in their ability to concentrate and arrive in class ready to learn.[5]

Rhode Island was one of only three states to see a marked increase in the proportion of schools offering breakfast in 2000. This is the third year in a row that Rhode Island had such an increase, which was the largest proportional increase in the country.[6] Due to recent legislative changes requiring school breakfast in all schools, 100% of Rhode Island schools offered the School Breakfast Program in the Fall of 2000. In 1995, only 38% of Rhode Island public schools offered the School Breakfast Program.[7]

Federal and state funds are available to support the costs of the School Breakfast Program. To receive a reduced-price meal, household income must be below 185% of the federal poverty level. For free meals, household income must fall below 130% of poverty. Children in Food Stamp and Family Independence Program households are automatically eligible for free meals. Children who participate in the School Breakfast Program have better school attendance, are more likely to arrive at school on time, and have higher standardized test scores than non-participants.[8]

Percentage of Low-Income Children Attending Schools that Offer the School Breakfast Program, Rhode Island and Core Cities, 1995 to 2000



◇ The percentage of low-income students attending schools offering the School Breakfast Program has increased from 64% in the Fall of 1995 to 100% in the Fall of 2000.[9]

◇ Over the last three years, the legislature has gradually increased the requirements for the number of schools mandated to provide school breakfast. In the 2000 legislative session, the Rhode Island General Assembly strengthened the School Breakfast law that first passed in 1998 by expanding the program to include all public schools.[10]

◇ Although all schools are now mandated to offer the School Breakfast Program, many students still do not participate. In the 1999-2000 school year, for every 100 Rhode Island students enrolled in the free and reduced price School Lunch Program only 30 accessed the School Breakfast Program. This compares with a ratio of 42 per 100 students in the U.S. as a whole. Rhode Island ranks 46th worst in the country for student participation in the School Breakfast Program.[11]

◇ The expansion of School Breakfast Programs to all children without regard to income eligibility significantly improves the number of low-income children who access the program by removing the stigma often associated with participation in school breakfast.[12] Central Falls is the only district in the state that offers school breakfast at no charge to all students.[13]

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Table 8. **Low-Income Children Attending Schools that Offer School Breakfast, Rhode Island, Fall 2000**

SCHOOL DISTRICT	TOTAL NUMBER OF SCHOOLS IN DISTRICT	NUMBER OF LOW-INCOME STUDENTS IN DISTRICT	NUMBER OF LOW-INCOME STUDENTS ATTENDING SCHOOLS WITH BREAKFAST	PERCENT OF LOW-INCOME STUDENTS ATTENDING SCHOOLS WITH BREAKFAST
Barrington	6	62	62	100%
Bristol-Warren	11	1,012	1,012	100%
Burrillville	5	457	457	100%
Central Falls	7	3,366	3,366	100%
Chariho	6	476	476	100%
Coventry	9	799	799	100%
Cranston	23	2,015	2,015	100%
Cumberland	9	588	588	100%
East Greenwich	6	125	125	100%
East Providence	15	2,020	2,020	100%
Exeter-W. Greenwich	4	248	248	100%
Foster	1	49	49	100%
Foster-Glocester	2	133	133	100%
Glocester	2	126	126	100%
Jamestown	2	36	36	100%
Johnston	8	595	595	100%
Lincoln	7	356	356	100%
Little Compton	1	34	34	100%
Middletown	6	546	546	100%
Narragansett	3	230	230	100%
Newport	9	1,335	1,335	100%
New Shoreham	1	12	12	100%
North Kingstown	10	548	548	100%
North Providence	9	668	668	100%
North Smithfield	4	169	169	100%
Pawtucket	16	5,741	5,741	100%
Portsmouth	6	173	173	100%
Providence	51	20,647	20,647	100%
Scituate	5	158	158	100%
Smithfield	6	174	174	100%
South Kingstown	8	455	455	100%
Tiverton	6	307	307	100%
Warwick	26	2,045	2,045	100%
Westerly	7	578	578	100%
West Warwick	6	1,196	1,196	100%
Woonsocket	14	3,668	3,668	100%
Core Cities	*97*	*34,757*	*34,757*	*100%*
Remainder of State	*220*	*16,390*	*16,390*	*100%*
Rhode Island	*317*	*51,147*	*51,147*	*100%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, Fall 1999 and 2000. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

Number of low-income students is the number of students eligible for and enrolled in free or reduced price lunches in the Fall of 1999. Low-income students attending schools with breakfast is the percentage of students enrolled in free or reduced priced lunches who attend schools serving breakfast in the Fall of 2000 (based on 1999 eligibility figures). Half-day kindergarten, private schools and residential child care facilities may offer the School Breakfast Program, but are not included in these calculations.

The denominator is the number of children enrolled in the public school who are eligible for and enrolled in free or reduced price lunches in the Fall of 2000, (based on 1999 eligibility figures). Half-day kindergarten is not included .

References for Indicator

[1,2,3] *Statements on the Link Between Nutrition and Cognitive Development in Children* (1998). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

[3,4,5,6] *School Breakfast Scorecard 2000: FRAC's Annual Status Report on the School Breakfast Program* (2000). Washington, DC: Food Research and Action Center.

[4] Andrews, M. et. al. (2000). *Food Insecurity in the US, 1999*. Washington, DC: U.S. Department of Agriculture.

[7] Rhode Island Department of Elementary and Secondary Education, Office of School Food Services, Fall 1995 and Fall 2000.

[8] Rhode Island Department of Elementary and Secondary Education, Office of School Food Service, Fall 1995 and Fall 2000, Calculations by Rhode Island KIDS COUNT.

[9] Flynn, B. ed. "This Week at the George Wiley Center, Legislative Wrap-Up Issue," Issue XLV (July 2000). Pawtucket, RI: The George Wiley Center.

[10] Marcone, L., *A Guide to Universal Free School Breakfast Program* (March 1999). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy; and, *Evaluation of the Universally-Free School Breakfast Program Demonstration Project: Central Falls, Rhode Island* (1996). Medford, MA: Tufts University, Center on Hunger, Poverty, and Nutrition Policy.

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Health

My People

By Langston Hughes

The night is beautiful
So the faces of my people.

The stars are beautiful,
So the eyes of my people.

Beautiful, also, is the sun.
Beautiful, also, are the souls of my people.

Children's Health Insurance

DEFINITION

Children's health insurance is the percentage of children under age 19 who were covered by any kind of public or private health insurance, including Medicaid during the previous calendar year. These data reflect only those who were insured through the entire year and do not include those who were insured for only part of the year.

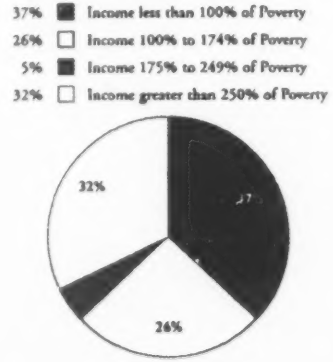
SIGNIFICANCE

Health care is vital to every child's healthy growth and development. Lack of insurance coverage makes it difficult to obtain primary and specialty care – including preventive health care, comprehensive treatment for acute and chronic illness, mental health services, dental care, and prescriptions.[1] Insured children are more likely than uninsured children to receive medical care for common conditions like asthma and ear infections – illnesses that if left untreated can lead to more serious health problems.[2,3] Uninsured Rhode Islanders are eight times more likely not to see a doctor due to cost than Rhode Islander's with private insurance.[4]

A parent's employment-related insurance coverage and eligibility for Medicaid or RIte Care are the most important factors in determining whether children have health insurance and the type of coverage.[5] Many low-income working families do not know that they qualify for government-sponsored health insurance.[6]

RIte Care, Rhode Island's Medicaid managed care program, is available to children in families with incomes up to 250% of the federal poverty line. Of the 106,554 RIte Care clients enrolled as of December 31, 2000, three-quarters (79,738) were children under age 19. Low-income parents of eligible children can enroll in RIte Care if family income is less than 185% of poverty. There were 17,607 low-income parents enrolled in RIte Care as of December 31, 2001.[7]

Children Under Age 19 without Health Insurance, by Poverty Level, Rhode Island, 1999


37% Income less than 100% of Poverty
26% Income 100% to 174% of Poverty
5% Income 175% to 249% of Poverty
32% Income greater than 250% of Poverty
32%
26%

n = 19,000

Source: U.S. Bureau of the Census, Current Population Survey, 1998-2000 average. Compiled by The Annie E. Casey Foundation.

Uninsured Children in Rhode Island, 1999

◆ As of 1999, 8% of Rhode Island children under age 19 were uninsured. Just over two-thirds (68%) of the 19,000 uninsured children in Rhode Island live in families under 250% of the federal poverty level and are therefore eligible to enroll in RIte Care.[8]

◆ Sixty-eight percent of Rhode Island's uninsured children live in working families. Of these, 46% live in families with incomes below 200% of poverty.[9]

◆ Racial and ethnic minorities are more likely to be uninsured than non-Hispanic Whites.[10] Poor and moderate income families often are unable to afford the cost of employer-sponsored health plans or work for employers that do not offer health insurance.[11]

Employer-Sponsored Health Insurance

◆ Cost of premiums for employer-sponsored health insurance rose 8.3% nationally between Spring 1999 and Spring 2000, driving annual premiums to $2,426 for single coverage and $6,381 for family coverage.[12]

◆ Rhode Island surveys of parents indicate that the top reason children and teenagers in Rhode Island are uninsured is because health insurance offered through the parent's employer is too expensive. Average premium costs in 1999 were between $65 and $102 per week.[13]

◆ RIte Share, Rhode Island's health insurance premium assistance program, was designed to enable RIte Care eligible families to participate in employer-sponsored health insurance. RIte Share will pay the employee's share (for an employee with a RIte Care eligible family member) of the cost for enrolling in an approved employer-sponsored family or individual health insurance plan.[14]

Table 9.

Children Under Age 19 Receiving Medical Assistance, Rhode Island, December 2000

CITY/TOWN	Rite Care FIP	Rite Care Non-FIP	SSI	Other	Total
Barrington	39	95	11	31	176
Bristol	218	413	30	21	682
Burrillville	152	417	32	41	642
Central Falls	1,896	1,496	174	313	3,879
Charlestown	66	197	12	11	286
Coventry	304	792	56	53	1,205
Cranston	1,451	1,968	181	172	3,772
Cumberland	208	460	38	78	784
East Greenwich	79	150	15	24	268
East Providence	848	1,511	125	89	2,573
Exeter	27	121	2	13	163
Foster	34	96	1	10	141
Glocester	63	172	16	15	266
Hopkinton	56	240	10	5	311
Jamestown	16	50	4	4	74
Johnston	466	773	57	27	1,323
Lincoln	187	357	30	39	613
Little Compton	9	56	4	3	72
Middletown	112	364	37	23	536
Narragansett	108	237	15	33	393
Newport	1,089	889	87	45	2,110
New Shoreham	7	13	1		21
North Kingstown	326	621	43	47	1,037
North Providence	510	723	58	56	1,347
North Smithfield	44	112	12	19	187
Pawtucket	3,783	3,497	421	436	8,137
Portsmouth	75	240	13	33	361
Providence	16,245	10,689	1,584	5,336	33,854
Richmond	75	112	17	28	232
Scituate	43	170	7	20	240
Smithfield	93	207	17	24	341
South Kingstown	232	431	46	38	747
Tiverton	112	270	30	12	424
Warren	192	298	15	10	515
Warwick	1,046	2,070	201	122	3,439
West Greenwich	34	110	6	8	158
West Warwick	788	1,165	73	68	2,094
Westerly	382	642	36	36	1,096
Woonsocket	2,679	2,030	310	54	5,073
Out-of-State	*2*	*0*	*18*	*0*	*20*
Unknown	*5*	*0*	*0*	*0*	*5*
Core Cities	*25,692*	*18,601*	*2,576*	*6,184*	*53,053*
Remainder of State	*8,503*	*15,674*	*1,295*	*1,213*	*26,685*
Rhode Island	*34,195*	*34,275*	*3,871*	*7,397*	*79,738*

Source of Data for Table/Methodology

Rhode Island Department of Human Services, MMIS Database, December 31, 2000. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The column labeled "RIte Care/FIP" is the number of children enrolled in RIte Care as of December 31, 2000 who also participate in the Family Independence Program. "RIte Care, Non-FIP" includes all other RIte Care participants under the age of 19 and pregnant women. "SSI" is children enrolled in fee-for-service Medicaid because they receive SSI. "Other" includes foster children and non-SSI children with disabilities who are enrolled in fee-for-service Medicaid. The Providence numbers for "other" include foster children who may live in other towns, because the DHS database lists foster children as Providence residents for administrative purposes.

References for Indicator

[43] "Health Insurance Coverage" in *The Future of Children* Vol 5, No. 3 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[44] *Uninsured in America: A Chartbook* (May 2000). Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

[45] *The Uninsured and Their Access to Health Care* (January 2000). Washington, DC: The Kaiser Commission on Medicaid and the Uninsured.

[46] Griffen, J. (October 2000). *Does Health Insurance Make a Difference? Difference in Health Status and Access to Care for Rhode Islanders' Ages 18-64 By Insurance Status.* Cranston, RI: Rhode Island Department of Human Services, Medicaid Research and Evaluation Project.

[47] Rhode Island Department of Human Services, MMIS Database, December 31, 2000.

[48] U. S Bureau of the Census, Current Population Survey, 1998-2000 average. Compiled by The Annie E. Casey Foundation.

[49] Brown, E. R., Ojeda, V.D., Wyn, R. and Levan, R. (April 2000). *Racial and Ethnic Disparities in Access to Health Insurance and Health Care.* Menlo Park, CA: UCLA Center for Health Policy Research and the Kaiser Family Foundation.

[50] *Employer Health Benefits: 2000 Annual Survey* (September 2000). Menlo Park, CA: The Kaiser Family Foundation and Health Research and Educational Trust.

[51] Griffen, J. (1999). *Uninsured in Rhode Island: Results of Focus Groups.* Cranston, RI: Rhode Island Department of Human Services.

[52] *Health Reform Rhode Island 2000: RIte Care Stabilization Implementation Plan* (August 2000). Cranston, RI: Rhode Island Department of Human Services.

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Access to Dental Care

DEFINITION

Access to dental care is the percentage of children under age 21 who are enrolled in RIte Care or Medicaid fee-for-service who have received dental prevention or treatment services during state fiscal year 2000 (July 1, 1999 through June 30, 2000).

SIGNIFICANCE

Children who receive an inadequate level of dental care or no dental care at all can develop long-term oral health problems and are more likely to experience dental conditions that require emergency treatment.[1] Preschool children with untreated dental caries (tooth decay) are more likely to develop poor eating habits, to have difficulty socializing with peers, and to have speech problems.[2] Chronic dental problems in school-age children and adolescents can lead to poor self-image, lack of concentration, absenteeism, and reduced school performance.[3]

Children without dental insurance are three times as likely as privately-insured children to be unable to access dental care when needed.[4] For children in low-income families, the efficacy of public dental insurance is a critical factor in access to dental prevention and treatment.[5] Barriers to obtaining oral health services for children insured through RIte Care or Medicaid include difficulty finding a dental provider who will accept Medical Assistance coverage and lack of parental education on the need for dental prevention and treatment services.[6,7]

Children in families with incomes below the poverty line and minority children have the greatest extent of untreated dental problems.[8,9] The National Institute of Dental Research reports that 80% of tooth decay occurs in only 25% of U.S. children and adolescents, mostly low-income children.[10]

Obtaining services from dental specialists is especially difficult for children covered through public health insurance programs.[11] Children with disabilities or special health care needs may also have problems accessing providers that are equipped to address their special needs.[12]

In 1996, 31% of Rhode Island children under age 5 and 26% of children between ages 6 and 18 were uninsured for dental services.[13] Of all Rhode Island children enrolled in RIte Care or Medicaid fee-for-service, one-in-three accessed dental prevention or treatment services in fiscal year 2000.[14]

80

Early Childhood Caries (Baby Bottle Tooth Decay)

◇ Early childhood caries is rampant decay in the primary teeth of infants and toddlers. The decay results from putting a child to bed with a bottle containing a sugary liquid (such as juice, milk, or infant formula) or allowing a child to drink from a bottle throughout the day.[15]

◇ Nationally, 3% to 10% of young children have early childhood caries. This rate is significantly higher among children from low-income families; up to 20% of children from low-income families have this condition.[16]

◇ Treatment of early childhood caries often requires extensive restorative work, stainless steel crowns, and tooth extraction. Dental health insurance increases the likelihood that needed treatment is provided.[17]

◇ Prevention of early childhood caries requires parent education regarding healthy child nutrition, on-going preventative dental care, and dental treatment.[18]

Availability of Dental Services for Rhode Island's Low-Income Children

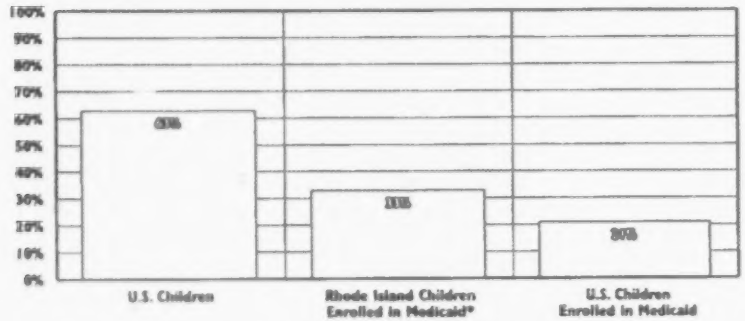
◇ The federal Medicaid program mandates that states provide comprehensive dental services to eligible children up to age 21, and entitles RIte Care (Rhode Island's Medicaid Managed Care program) recipients to comprehensive dental prevention and treatment services.

◇ States are required to recruit dentists to provide oral health services through the Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program, to assure that providers are performing the required services, and to locate and educate eligible families about EPSDT services.

◇ Participation rates of dentists who serve low-income children are very low in Rhode Island. Statewide, there are 113 RIte Care enrollees for each Medicaid dental provider. In the five core cities there are more than 220 RIte Care enrollees per Medicaid dental provider.[19]

81

Percentage of Children with a Dental Visit in the Previous Year



**Includes RIte Care and Medicaid fee-for-service.*

Source: Office of the Inspector General (1996). *Children's Dental Services Under Medicaid: Access and Utilization.* Washington, DC: U.S. Department of Health and Human Services; Rhode Island Department of Human Services, January 2001, includes all children enrolled in RIte Care and Medicaid fee-for-service.

◇ Approximately 63% of the total U.S. child population see a dentist annually.[20]

◇ Despite the entitlement to dental services under Medicaid EPSDT, only one-in-five children enrolled in Medicaid in the U.S. have received a single dental visit over the course of one year.[21]

◇ Of all Rhode Island children under age 21 enrolled in public insurance programs, one-in-three accessed dental prevention or treatment services in fiscal year 2000.[22]

◇ Children eligible for Medicaid services experience twice the ratio of untreated dental disease as more affluent children.[23]

References

[1,16,23] Edelstein, B.L. (May 1998). "Crisis in Care: The Facts Behind Children's Lack of Access to Medicaid Dental Care" *NCEMCH Policy Brief.* Washington, DC: Georgetown University, National Center for Education in Maternal and Child Health.

[2,16,17] *Promoting Awareness, Preventing Pain: Facts on Early Childhood Caries* (June 1999). Washington, DC: Georgetown University, National Center for Education in Maternal and Child Health.

[3,17] *Oral Disease: A Crisis Among Children in Poverty* (May 1998). Washington, DC: Georgetown University, National Center for Education in Maternal and Child Health.

[4,5,6,8,9] Lewit, E.M. and Kerrebock, N. (Spring 1998). "Child Indicators: Dental Health" in *The Future of Children,* Vol. 8, No. 1. Los Altos, CA: The Center for the Future if Children, David and Lucile Packard Foundation.

[7] "Options for the Delivery of Medicaid Dental Services" (March 1999). Cranston, RI: Rhode Island Department of Human Services, Division of Health Care Quality, Financing and Purchasing.

[10] Milbank Memorial Fund, Reforming States Group (1999). *Pediatric Dental Care in CHIP and Medicaid. Paying for What Kids Need: Getting Value for State Payments.* New York, NY: Milbank Memorial Fund.

[11] Rhode Island Department of Health, Office of Health Statistics, *Rhode Island Health Interview Survey,* 1996.

[12,21] Rhode Island Department of Health and Human Services, January 2001.

[13,18] Clark, M., and Holt, K. (Eds). *Early Childhood Caries Resource Guide* (November 1998). Arlington, VA: National Center for Education in Maternal and Child Health.

[14] *Study of Alternatives for Delivery of Medicaid Dental Services* (1998). Cranston, RI: Rhode Island Department of Human Services.

[15] U.S. Department of Health and Human Services (1990). *Healthy People 2000.* Washington, DC: U.S. Government Printing Office.

[19] Office of the Inspector General (1996). *Children's Dental Services Under Medicaid: Access and Utilization.* Washington, DC: U.S. Department of Health and Human Services.

[20] *Oral Health in America: A Report of the Surgeon General* (May 2000). Washington, DC: U.S. Department of Health and Human Services, U.S. Public Health Service, National Institutes of Health, National Institutes of Dental and Craniofacial Research.

Children's Mental Health

DEFINITION

Children's mental health is the number of children under age 18 using the mental health treatment system in Rhode Island.

SIGNIFICANCE

Mental health in childhood and adolescence is defined by the U.S. Surgeon General as the achievement of expected developmental, cognitive, social and emotional milestones and by the presence of secure attachments, satisfying social relationships, and effective coping skills. Only serious deviations from expected cognitive, social and emotional development are considered mental disorders.[1]

One in five U.S. children ages 9 to 17 has a diagnosable mental or addictive disorder. One in ten suffers severe functional impairment as a result of their disorders.[2]

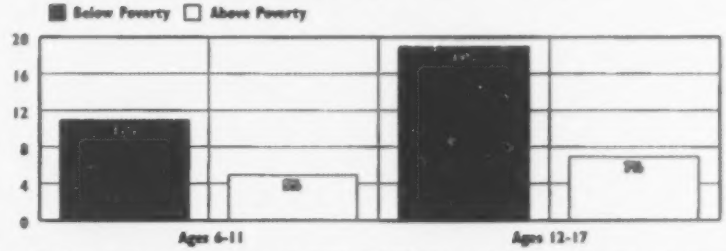
Mental health problems affect children of all backgrounds. Children most at risk for developing a mental disorder or experiencing problems in social-emotional development include those with prenatal damage from exposure to alcohol, illegal drugs, and tobacco; those born with low birth weight, difficult temperment, or an inherited predisposition to a mental disorder; children with external risk factors such as poverty, deprivation, abuse and neglect, unsatisfactory relationships, or exposure to traumatic events; and children whose parent has a mental health disorder.[3]

Children with mental health needs can be found in every system serving children. Primary health care settings and schools are important sites for the identification of children with mental health needs. The multiple problems associated with mental illness in children can best be addressed by a systems approach in which multiple sectors work collaboratively to meet the child and family's needs.[4]

The Rhode Island Child and Adolescent Service System Program (CASSP) is a state-wide system of care which helps parents and communities plan family-focused services for children with emotional, behavioral and/or mental health challenges. CASSP services are carried out through eight Local Coordinating Councils (LCC's) managed by community mental health centers across the state.[5]

Mental health services are provided through RIte Care as part of the managed care benefit plan. In 1999, 7% of all children enrolled in RIte Care received outpatient mental health services, at an average cost of $408 per child.[6] Inpatient hospitalization of children enrolled in RIte Care increased between 1998 and 1999, with an increased number of admissions and an increased length of stay.[7]

Behavioral and Emotional Problems, By Poverty Status and Age, United States, 1997



Source: Vandivere, S., Moore, K.A., and Brown, B. (2000). *Child Well-Being at the Outset of Welfare Reform: An Overview of the Nation and 13 States.* Washington, DC: Urban Institute.

◇ The National Survey of America's Families asked parents a series of questions about their children's emotional and behavioral well-being. Parents who had incomes below the poverty level were much more likely to respond that their child or adolescent had emotional or behavioral problems.[8]

◇ The National Survey of American Families combined the following factors to create a family stress index. Children in families with two or more of these factors are considered to be living in a stressful family environment: inability to pay the rent, mortgage or utility bills; more than two people per bedroom; no food or money to buy food; not confident that family members can get health care if needed; parent or parents' partner is in poor health or has a physical, learning, or mental health condition; child is in poor health or has a physical, learning or mental health condition.[9]

◇ Stressful family situations can have negative effects on the mental health of children and adolescents. Children who live in poverty are far more likely to live in stressful family situations. Half of all poor children live in stressful family environments compared to one in 20 children living in families with incomes three times the federal poverty level.[10]

Rhode Island Community Mental Health Centers

◇ The eight Community Mental Health Centers (CMHCs) in Rhode Island are the primary source of public mental health treatment services available in the state.[11] As of December 31, 2000, the community mental health centers were providing services to 4,451 children. Two-thirds were male and one-third were female. Of these children, 24% were being treated for attention deficit disorder and 12% for depressive or mood disorders. More than one in three children receiving treatment at the community mental health centers were diagnosed with serious mental illnesses.[12]

◇ More than half (2,493) of the children receiving services through community mental health centers as of December 31, 2000 were between the ages of 12 to 17. One-third (1,677) were between ages 6 and 11 and 281 were under age 6.[13]

◇ One in five children accessing services through the community mental health centers use commercial health insurance as primary payment source. One-fifth used Medicaid fee-for-service and one-fifth used RIte Care to pay for services received at the community mental health centers. The remainder use a variety of funding sources.[14]

Hospitals

◇ Bradley Hospital is Rhode Island's largest psychiatric center for children. In 2000, 781 children were discharged from Bradley Hospital. 5,634 children participated in its outpatient treatment program and 11,734 home health visits were provided.[15]

◇ Butler Hospital provides a wide range of psychiatric services for children and adolescents. In 2000, Butler Hospital provided services to 1,473 children and youth in its outpatient and partial hospital programs. 865 children and youth were admitted for in-patient care, of these, 42% were diagnosed with depressive disorder.[16]

Schools

◇ Nationally, the public school system is the sole provider of services for nearly half of all children receiving mental health services.[17] School systems are mandated to provide special education services to children and adolescents whose disabilities interfere with their education.[18]

◇ Schools serve as a primary entrance point to the mental health system. In the 1999-2000 school year, 3,572 Rhode Island children between the ages of 3 and 22 were identified within the special education system as being disabled because of mental health related issues. Of these, two-thirds were behaviorally disordered and one-third were mentally retarded.[19]

◇ School-based health centers in Rhode Island report high demand for mental health services. In the 1999-2000 school year the six school-based health centers reported 1,055 behavioral health visits. Two-thirds of these visits were for mood or anxiety-related problems.[20]

References

[1,2,3,4,10] *Mental Health: a Report of the Surgeon General* (1999). Washington, DC: Office of the Surgeon General.

[5] *CASSP System of Care and Regional Programs Factsheet* (2000). Rhode Island Department of Children Youth and Families.

[6,7] Annual Report (2000). Providence, RI: Rhode Island Governor's Advisory Council on Health.

[8] Vandivere, S., Moore, K.A., and Brown, B. (2000). *Child Well-Being at the Outset of Welfare Reform: An Overview of the Nation and 13 States.* Washington, DC: The Urban Institute and Child Trends.

[9,20] Moore, K.A. and Vandivere, S. (2000). *Stressful Family Lives: Child and Parent Well-Being.* Washington, DC: The Urban Institute and Child Trends.

[11] Mental Health Advancement Resource Center website: www.mharc.com (January 2001).

[12,13,14] Rhode Island Department of Mental Health Retardation and Hospitals, December 2000.

[15] Bradley Hospital, January 1, 2000 through December 31, 2000.

[16] Butler Hospital, January 1, 2000 through December 31, 2000.

[17] School Based Health Centers in Rhode Island (2000). Providence, RI: Rhode Island Department of Health.

[18] Rhode Island Department of Elementary and Secondary Education, 1999–2000.

[19] Rhode Island Department of Health, School Based Health Center Reports, School Year 1999–2000.

Women and Children Receiving WIC

DEFINITION

Women and children receiving WIC is the percentage of eligible women, infants and children served by the Special Supplemental Nutrition Program for Women, Infants and Children (WIC).

SIGNIFICANCE

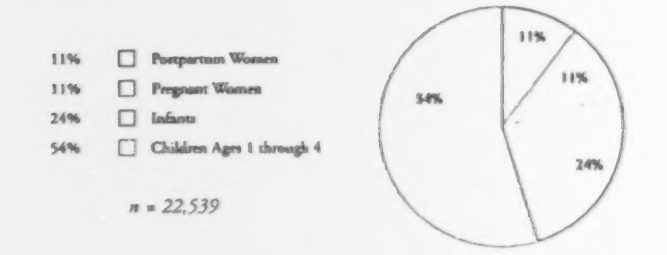
The Special Supplemental Nutrition Program for Women, Infants and Children is a preventive program providing nutritious food, nutrition education, and improved access to health care.[1] This federally-funded program serves pregnant, postpartum and breastfeeding women, infants, and children less than five years of age. Household income must be below 185% of the poverty level. In addition, any individual who participates in the Food Stamp program, RIte Care, Medicaid, cash assistance through the Family Independence Program, or is a member of a family in which a pregnant woman or infant receives Medicaid benefits, is deemed automatically income eligible. Participants must have a specified health or nutritional risk, such as abnormal weight gain during pregnancy or iron deficiency anemia.[2]

All WIC participants receive vouchers for foods such as eggs, cereal, milk, cheese, infant formula, juice, carrots, and high protein foods (beans, peanut butter, tuna fish) that can be redeemed at retail stores.[3] The WIC Farmer's Market Nutrition Program improves the intake of fresh fruits and vegetables by providing coupons to WIC participants to help them to purchase fresh produce at local farmers' markets. In Rhode Island in 2000, 11 farmers markets provided fresh fruits and vegetables to more than 13,000 recipients.[4]

The WIC program is closely connected to the health care delivery system. Participation in WIC increases the likelihood that women will receive early, regular prenatal care and that their children will get regular pediatric care and immunizations.[5] WIC promotes breastfeeding as the optimal method of infant feeding. Breastfeeding mothers qualify for a special food package and program eligibility is extended for up to one year.[6] In the last 3 months of 2000, 12.9% of infants participating in the WIC program were being breastfed.[7]

WIC protects infants and children from iron-deficiency anemia and other nutrition-related health problems.[8] By protecting a child's cognitive development, WIC results in savings for special education that may have otherwise been incurred due to malnutrition in infancy and early childhood.[9] Mothers and children who are poor, minority, or poorly educated benefit most.[10]

Women, Infants, and Children Served by WIC, Rhode Island, December 2000



Source: Rhode Island Department of Health, Division of Family Health, WIC Program, December 2000.

Access to WIC in Rhode Island

◇ WIC is not an entitlement program and is not funded at a level that is sufficient to serve all eligible women, infants, and children.[11] Total WIC participation in Rhode Island increased from 3,173 women, infants and children in 1977 to 22,539 in 2000.

◇ As of December 2000, 69% of eligible women, infants and children were served across the state.[12] Four of the five cities with the highest child poverty rates – Providence, Pawtucket, Woonsocket, and Central Falls – have WIC participation rates that exceed the statewide average of 69%. In Newport, only 48% of women, infants, and children eligible for WIC were served.[13]

Table 10. **Women, Infants and Children Receiving WIC, Rhode Island, December 2000**

CITY/TOWN	ESTIMATED* NUMBER ELIGIBLE	NUMBER PARTICIPATING	% OF ELIGIBLE PARTICIPATING
Barrington	211	32	15%
Bristol	403	210	52%
Burrillville	427	224	52%
Central Falls	1,642	1,386	84%
Charlestown	105	76	72%
Coventry	592	323	54%
Cranston	1,753	875	49%
Cumberland	554	229	41%
East Greenwich	241	48	19%
East Providence	1,205	746	61%
Exeter	13	50	100%*
Foster	10	36	100%*
Glocester	293	56	19%
Hopkinton	33	92	100%*
Jamestown	96	6	6%
Johnston	598	354	59%
Lincoln	360	144	40%
Little Compton	63	13	20%
Middletown	694	294	42%
Narragansett	71	80	100%*
Newport	1,332	644	48%
New Shoreham	39	3	7%
North Kingstown	370	253	68%
North Providence	262	398	100%*
North Smithfield	59	51	86%
Pawtucket	3,198	2,701	84%
Portsmouth	249	109	43%
Providence	11,280	8,747	77%
Richmond	24	68	100%*
Scituate	75	53	70%
Smithfield	174	75	43%
South Kingstown	402	212	52%
Tiverton	260	115	44%
Warren	156	132	84%
Warwick	1,613	856	53%
Westerly	648	318	49%
West Greenwich	38	22	57%
West Warwick	777	696	89%
Woonsocket	2,566	1,812	70%
Core Cities	*20,018*	*15,290*	*76%*
Remainder of State	*12,868*	*7,249*	*56%*
Rhode Island	*32,886*	*22,539*	*69%*

**Estimates are based on 1990 Census, and do not reflect recent increases in eligible population.*

Women with Delayed Prenatal Care

DEFINITION

Women with delayed prenatal care is the percentage of women beginning prenatal care in the second or third trimester of pregnancy or receiving no prenatal care at all. Data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

Timely and comprehensive prenatal care increases the likelihood of delivering a healthy infant of normal birthweight, results in fewer complications at birth, and reduces health care costs.[1] Delaying the start of prenatal care to the second trimester increases health risks for both mother and baby.[2] Women receiving late or no prenatal care are at increased risk of having infants who are low birthweight, who are stillborn, or who die within the first year of life.[3]

Prenatal care offers the opportunity to screen for and treat disease conditions that increase the risk for poor birth outcomes. Effective prenatal care screens for and intervenes with non-medical conditions including smoking, substance use, physical abuse, nutritional deficiencies, and needs for food, clothing and shelter.[4] Women who receive adequate prenatal care are more likely to get preventive health care for their children, such as scheduling well-baby visits, immunizations, and regular health checkups.[5,6]

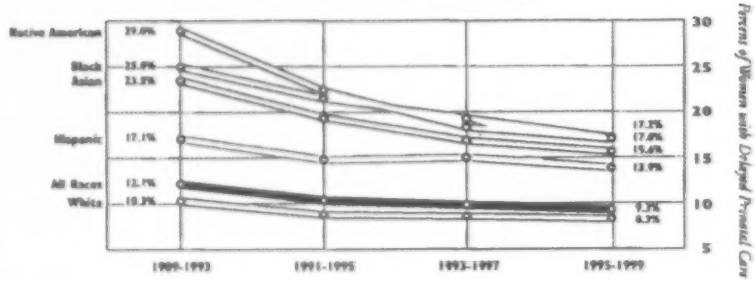
Early prenatal care is especially important for women at increased medical and social risk.[7] Several studies have indicated that low-income women who receive enhanced prenatal care services experience improved birth outcomes. Enhanced prenatal care services may include outreach, case management, risk assessment, smoking cessation, nutritional and psychosocial counseling, health education, guidance on infant and child development, referrals to WIC and other social services, and home visits.[8]

Common reasons for women to delay the start of prenatal care until later in the pregnancy include being a teen mother, not realizing they are pregnant, not having the money or insurance to pay for medical visits, no connection to a medical provider, and/or difficulty with transportation.[9,10]

One in ten (9.3%) Rhode Island women delay the start of prenatal care past the first trimester.[11] Rhode Island has the lowest rate of delayed prenatal care in the country.[12]

92

Delayed Prenatal Care, by Race/Ethnicity, Rhode Island, 1989-1999



◇ Over the past decade, the rate of delayed prenatal care has decreased for Rhode Island women in all racial/ethnic groups. Black, Asian, Hispanic and Native American women continue to be more likely to begin prenatal care later than the first trimester of pregnancy.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, five-year averages of data from 1989-1993, 1991-1995, 1993-1997, and 1995-1999. Data for 1996-1999 are provisional.

Access to Prenatal Care

◇ Medicaid expansions targeted at improving prenatal care for low-income women have allowed Rhode Island to expand coverage through RIte Care to uninsured pregnant women with incomes up to 350% of the poverty level.[13]

◇ Over the past decade, the communities of Providence and Newport have significantly improved access to prenatal care. Between 1988 and 1999, the percentage of women who delayed prenatal care decreased from 21.0% to 12.8% in Providence and from 20.3% to 10.9% in Newport.[14]

◇ Women who live in Pawtucket, Central Falls, and Woonsocket continue to be less likely to obtain prenatal care in their first trimester. Between 1995 and 1999, 20.7% of women in Central Falls received delayed or no prenatal care, more than twice the state rate.[15]

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Table 11. **Delayed Prenatal Care, Rhode Island, 1995-1999**

CITY/TOWN	# BIRTHS	# DELAYED CARE	% DELAYED CARE
Barrington	784	19	2.4%
Bristol	1,160	96	8.3%
Burrillville	800	61	7.6%
Central Falls	1,627	336	20.7%
Charlestown	435	30	NA
Coventry	1,955	109	5.6%
Cranston	4,175	280	6.7%
Cumberland	1,691	91	5.4%
East Greenwich	582	27	4.6%
East Providence	2,592	221	8.5%
Exeter	365	21	NA
Foster	198	10	NA
Glocester	500	30	6%
Hopkinton	492	47	NA
Jamestown	203	7	NA
Johnston	1,570	95	6.1%
Lincoln	984	55	5.6%
Little Compton	145	13	NA
Middletown	1,128	69	6.1%
Narragansett	707	24	3.4%
Newport	1,681	184	10.9%
New Shoreham	76	8	NA
North Kingstown	1,500	53	3.5%
North Providence	1,608	95	5.9%
North Smithfield	524	26	5%
Pawtucket	5,045	736	14.6%
Portsmouth	957	40	4.2%
Providence	13,249	1,691	12.8%
Richmond	471	29	NA
Scituate	518	25	4.8%
Smithfield	844	30	3.6%
South Kingstown	1,329	46	3.5%
Tiverton	653	48	7.4%
Warren	589	53	9%
Warwick	4,563	242	5.3%
Westerly	1,431	178	12.4%
West Greenwich	323	11	NA
West Warwick	2,009	185	9.2%
Woonsocket	2,954	468	15.8%
Core Cities	*24,556*	*3,415*	*13.9%*
Remainder of State	*37,861*	*2,374*	*6.3%*
Rhode Island	*62,417*	*5,789*	*9.3%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1995-1999. Data for 1996-1999 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

NA: Percentages were not calculated for cities and towns with less than 500 births, as percentages for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1995-1999. Data for 1996-1999 are provisional.

References for Indicator

[1,2] Child Trends, Inc. and the U.S. Bureau of the Census (2000). *Trends in the Well-Being of America's Children and Youth: 2000.* Washington, DC: U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation.

[3] *Prenatal Care in the United States: A State and County Inventory* - Volume 1 (1989). New York: The Alan Guttmacher Institute.

[4] Kiernan, L.V. (1991). *Alive and Well?: A Research and Policy Review of Health Programs for Poor Children.* New York: Columbia University, National Center for Children in Poverty.

[5] Alexander, G.R. & Korenbrot, C.C. (1995). "The Role of Prenatal Care in Preventing Low Birth Weight" in *The Future of Children: Low Birth Weight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[6] "New Data Show Prenatal, Postdelivery Progress" in *CDF Reports* (October 1998). Washington, DC: Children's Defense Fund.

[7] *Maternal and Child Health Principles in Practice: An Analysis of Select Provisions in Medicaid Managed Care Contracts* (1998). Washington, DC: Association of Maternal and Child Health Programs and George Washington University Medical Center, Center for Health Policy Research.

[8] "Entry Into Prenatal Care, United States, 1989-1997" (2000). *Morbidity and Mortality Weekly Report*, May, 2000, 49(18); 393-8.

[9] *KIDS COUNT Special Report. The Right Start: Conditions of Babies and Their Families in America's Largest Cities* (2000). Baltimore, MD: The Annie E. Casey Foundation.

[10,11] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1988-1999. Data for 1996-1999 are provisional.

[12] *Perinatal Profiles: Statistics for Monitoring State Maternal and Infant Health* (2000). White Plains, NY: March of Dimes.

[13] Griffin J. et al. (1999). "The Effects of a Medicaid Managed Care Program on the Adequacy of Prenatal Care in Rhode Island." *American Journal of Public Health*, April, 1999, Vol. 89, No. 4.

Low Birthweight Infants

DEFINITION

Low birthweight infants is the percentage of infants born weighing under 2,500 grams (5.5 pounds). The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

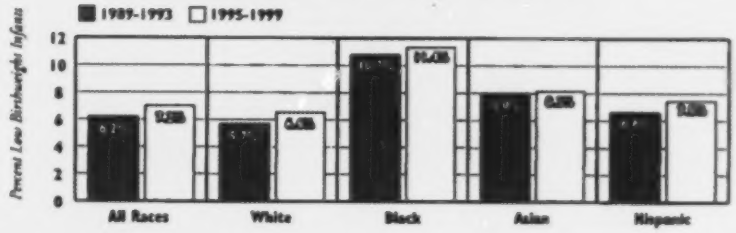
A baby's birthweight is a key indicator of newborn health and is directly related to infant survival, health and development. Babies born weighing less than 5.5 pounds are at greater risk for physical and developmental problems.[1] Babies are born small for a number of reasons: some are born too early (premature), some are born full-term but small for their gestational age, and some are born both premature and small.[2]

Low birthweight babies are at higher risk of death or long-term illness and disability than are infants of normal birthweight.[3] Low birthweight babies are 20 times more likely than babies of normal weight to die within the first year of life.[4] Low birthweight infants who survive are at greater risk for physical and developmental problems. Children who are now 6 to 15 years old, who were born low birthweight, are 50% more likely than children born of normal weight to be enrolled in a special education program.[5]

The incidence of low birthweight is strongly associated with poverty.[6] Prevention of low birthweight focuses on early and comprehensive prenatal care, adequate nutrition and weight gain, and smoking cessation. Smoking during pregnancy has been linked to 20% to 30% of low birthweight births and to long-term effects such as physical, mental, and cognitive impairments.[7] Black women are much more likely to have a low birthweight infant than women of any other racial or ethnic group.[8] Underlying the high rate of low birthweight among African-Americans in the U.S. is the higher rate of preterm delivery (babies born before 37 weeks gestation).[9] The causes of preterm delivery are not well understood; the higher rates are not completely explained by differences in socio-economic status, health status, or use of tobacco or other drugs.[10,11]

Between 1995 and 1999, there were 872 very low birthweight infants (weighing less than 1,500 grams or 3.3 pounds) born in Rhode Island, just over 1% of all births.[12] Very low birthweight babies are at especially high risk for chronic lung and respiratory problems, visual and hearing impairments, mental retardation, and developmental and learning disabilities.[13]

Low Birthweight Infants, by Race/Ethnicity, Rhode Island, 1989-1993 and 1995-1999



◇ Low birthweight rates for Black infants in Rhode Island are almost twice those for White infants, and are higher than those for other racial groups.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1989-1993 and 1995-1999. Data for 1996-1999 are provisional.

Increase in Multiple Births and Low Birthweight Infants

◇ Nationally, the percentage of low birthweight infants has steadily increased since 1984. In 1998, the rate (7.6%) was the highest since the 70's.[14] Two reasons for the increase in low birthweight infants are the growing number of twin, triplet and multiple births, and new developments in the neonatal field that make survival possible for low birthweight and preterm infants.[15,16]

◇ The increase in multiple births and the increasing number of low birthweight infants can partially be attributed to an increase in the use of fertility drugs and other reproductive technologies. Two-thirds of the increase in multiple births is due to an increase in use of fertility drugs by women of all ages.[18]

◇ Twins and other multiple births are more likely to be low birthweight.[17] Between 1989 and 1998, the number of multiple births in Rhode Island rose from 327 births annually to 500 births annually, an increase of 53%.[19]

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Table 12. **Low Birthweight Infants, Rhode Island, 1995-1999**

CITY/TOWN	# BIRTHS	# LOW BIRTHWEIGHT	% LOW BIRTHWEIGHT
Barrington	784	46	5.9%
Bristol	1,160	78	6.7%
Burrillville	800	47	5.9%
Central Falls	1,627	132	8.1%
Charlestown	435	26	NA
Coventry	1,955	110	5.6%
Cranston	4,175	317	7.6%
Cumberland	1,691	110	6.5%
East Greenwich	582	46	7.9%
East Providence	2,592	182	7%
Exeter	365	10	NA
Foster	198	11	NA
Glocester	500	29	5.8%
Hopkinton	492	40	NA
Jamestown	203	14	NA
Johnston	1,570	118	7.5%
Lincoln	984	61	6.2%
Little Compton	145	7	NA
Middletown	1,128	51	4.5%
Narragansett	707	49	6.9%
Newport	1,681	108	6.4%
New Shoreham	76	5	NA
North Kingstown	1,500	76	5.1%
North Providence	1,608	142	8.8%
North Smithfield	524	44	8.4%
Pawtucket	5,045	396	7.8%
Portsmouth	957	49	5.1%
Providence	13,249	1,182	8.9%
Richmond	471	22	NA
Scituate	518	37	7.1%
Smithfield	844	41	4.9%
South Kingstown	1,329	70	5.3%
Tiverton	653	31	4.7%
Warren	589	34	5.8%
Warwick	4,563	301	6.6%
Westerly	1,431	78	5.5%
West Greenwich	323	16	NA
West Warwick	2,009	156	7.8%
Woonsocket	2,954	231	7.8%
Core Cities	*24,556*	*2,049*	*8.3%*
Remainder of State	*37,861*	*2,454*	*6.5%*
Rhode Island	*62,417*	*4,503*	*7.2%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1995-1999. Data for 1996-1999 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

NA: Percentages were not calculated for cities and towns with fewer than 500 births, as percentages for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1995-1999.

References for Indicator

[a] "Infant Health Improving" in *CDF Reports*, Vol. 17, No. 12 (November 1996). Washington, DC: Children's Defense Fund.

[b,c,d] *America's Children: Key National Indicators of Well-Being* (2000). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[e] Lewit, E. et al. (1995). "The Direct Cost of Low Birth Weight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucile Packard Foundation.

[f,g,h] Paneth, N.S. (1995). "The Problem of Low Birthweight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucile Packard Foundation.

[i] Chomitz, V.R., Cheung, L.W.Y., and Lieberman, E., "The Role of Lifestyle in Preventing Low Birth Weight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children.

[j,k,l,m] Martin J. et al (1999). Births and Deaths: Preliminary Data for 1998. Washington, DC: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

[n] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1995-1999.

[o] Vohr, B.R. and Msall, M.E. (1997). "Neuropsychological and Functional Outcomes of Very Low Birthweight Infants" in *Seminars in Perinatology*, Vol. 21, No. 3 (June 1997); and Paneth, N.S. (1995). "The Problem of Low Birthweight" in *The Future of Children: Low Birthweight*, Vol. 5, No. 1 (Spring 1995). Los Altos, CA: The Center for the Future of Children, The David and Lucille Packard Foundation.

[p] "New Data Show Prenatal, Postdelivery Progress" in *CDF Reports* (October 1998). Washington, DC: Children's Defense Fund.

[q,r] Viner-Brown, S.I., Cain, R. and W.H. Hollinshead (2000). "Multiple Gestation Births in Rhode Island, 1989-1998" in *Health by Numbers*, Vol. 2, No. 6 (June 2000). Providence, RI: Rhode Island Department of Health, Office of Statistics.

Infant Mortality

DEFINITION

Infant mortality is the number of deaths occurring to infants under one year of age per 1,000 live births. The data are reported by place of mother's residence, not place of infant's birth.

SIGNIFICANCE

The infant mortality rate is an important measure of the well-being of infants, children, and pregnant women. Infant mortality is associated with a variety of factors, including women's health status, quality of and access to medical care, socioeconomic conditions, and public health practices. In the United States, about two-thirds of infant deaths are closely linked to low birthweight, preterm delivery, and events surrounding the prenatal period and delivery; about one-third are associated with conditions or events that arise after the delivery, which often reflect social or environmental factors.[1,2]

Communities with multiple problems such as poverty, poor housing conditions, and unemployment tend to have higher infant mortality rates than more advantaged communities.[3] Risk factors contributing to infant deaths include a lack of prenatal care and preventative care, short interpregnancy intervals, inadequate maternal nutrition, poor living conditions, and a mother who has received less than 12 years of education.[4,5]

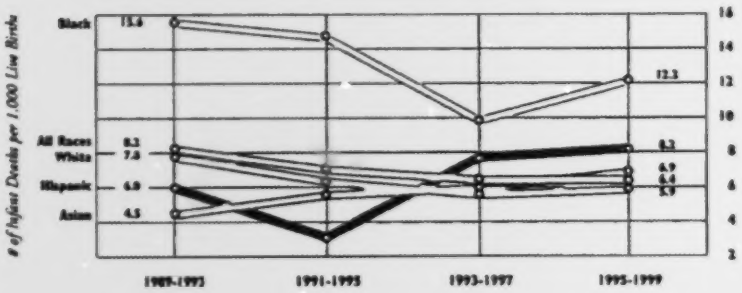
Infant mortality has two components: neonatal mortality, which is the number of deaths of infants younger than 28 days, and postneonatal mortality, the number of deaths of infants between 28 days and one year old. In 1999 in Rhode Island, 70 infants died before their first birthday; of these, 53 were younger than 28 days old. Forty-two of the 70 infants who died in 1999 were born very low birthweight (less than 1500 grams or 3.3 pounds); of these, 24 were live births less than 500 grams (1.1 pounds).[6]

U.S. Infant Mortality Rate Ranks Behind Other Countries

◇ 1998 preliminary data for the U.S. shows an infant mortality rate of 7.2 deaths per 1,000 live births.[7]

◇ In 1997, Rhode Island's infant mortality rate was 6.4 deaths per 1,000 live births.[8]

Infant Mortality Rates, by Race/Ethnicity, Rhode Island, 1989-1999



◇ Over the past decade, Rhode Island's infant mortality rate declined for White and Black infants, but increased for Hispanic and Asian infants. The Black infant mortality rate is twice the rate for White infants and higher than that of any other racial and ethnic group.

Source: Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, five-year averages of data from 1989-1993, 1991-1995, 1993-1997 and 1995-1999. Data for 1996-1999 are provisional.

Infant Mortality Rates Steadily Improve But Disparities Still Exist

◇ Improved access to prenatal care in the first trimester has contributed to a decrease in the infant mortality rates across the United States.[9] However, there are continuing racial and ethnic disparities in timely receipt of prenatal care. Between 1995 and 1999 in Rhode Island, 8.3% of White women delayed prenatal care until after the first trimester of pregnancy, compared to 17.2% of Black women and 13.9% of Hispanic women.[10]

◇ Infants born to women in the United States who do not graduate from high school have a higher infant death rate than infants of women who obtain a high school diploma. Nationwide in 1998, 22% of births in the U.S. occurred to women with less than 12 years of formal education.[11]

◇ In Rhode Island in 1998, 16% of births were to mothers with less than 12 years of education. In Providence, 29% of births were to women with less than 12 years of education.[12]

100

101

Table 13.

Number of Infant Deaths, Rhode Island, 1995-1999

CITY/TOWN	# BIRTHS	# INFANT DEATHS	RATE/1000 BIRTHS
Barrington	784	1	1.3
Bristol	1,160	4	3.4
Burrillville	800	5	6.3
Central Falls	1,627	12	7.4
Charlestown	435	2	NA
Coventry	1,955	6	3.1
Cranston	4,175	22	5.3
Cumberland	1,691	8	4.7
East Greenwich	582	3	5.2
East Providence	2,592	19	7.3
Exeter	365	1	NA
Foster	198	1	NA
Glocester	500	3	6.0
Hopkinton	492	3	NA
Jamestown	203	0	NA
Johnston	1,570	6	3.8
Lincoln	984	6	6.1
Little Compton	145	0	NA
Middletown	1,128	6	5.3
Narragansett	707	2	2.8
Newport	1,681	8	4.8
New Shoreham	76	1	NA
North Kingstown	1,500	5	3.3
North Providence	1,608	16	10.0
North Smithfield	524	3	5.7
Pawtucket	5,045	40	7.9
Portsmouth	957	4	4.2
Providence	13,249	128	9.7
Richmond	471	1	NA
Scituate	518	1	1.9
Smithfield	844	3	3.6
South Kingstown	1,329	6	4.5
Tiverton	653	3	4.6
Warren	589	1	1.7
Warwick	4,563	30	6.6
Westerly	1,431	4	2.8
West Greenwich	323	0	NA
West Warwick	2,009	18	9.0
Woonsocket	2,954	20	6.8
Core Cities	*24,556*	*208*	*8.5*
Remainder of State	*37,861*	*194*	*5.1*
Rhode Island	*62,417*	*402*	*6.4*

Source of Data for Table/Methodology

Rhode Island Department of Health, Division of Family Health, Maternal and Child Health Database, 1995-1999. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls. 1996-1999 data are provisional.

NA: Rates were not calculated for cities and towns with fewer than 500 births, as rates for small denominators are statistically unreliable.

The denominator is the total number of live births to Rhode Island residents from 1995-1999.

References for Indicator

[1] *America's Children: Key National Indicators of Well-Being* (2000). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[2] Paneth, N.S. (1995). "The Problem of Low Birth Weight" in *The Future of Children: Low Birth Weight*, Vol.5, No.1 (Spring 1995). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[3] UNICEF (2001). *The State of the World's Children: 2001*. New York: United Nations Children's Fund.

[4] *Perinatal Profiles: Statistics for Monitoring State Maternal and Infant Health* (2000). White Plains, NY: March of Dimes.

[5,11,12] KIDS COUNT *Special Report. The Right Start: Conditions of Babies and Their Families in America's Largest Cities* (2000). Baltimore, MD: The Annie E. Casey Foundation.

[6] Provisional data on 1999 births, Rhode Island Department of Health, Office of Vital Statistics, January 2001.

[7] Martin, J., et al. (1999). *Births and Deaths: Preliminary Data for 1998*. Hyattsville, MD: Centers for Disease Control and Prevention, National Center for Health Statistics and the National Vital Statistics System.

[8,10] Rhode Island Department of Health, Division of Family Health, Maternal and Child Health database, 1995-1999. Data for 1996-1999 are provisional.

[9] "New Data Show Prenatal, Postdelivery Progress" in *CDF Reports*, Vol. 17, No. 12 (October 1998). Washington, DC: Children's Defense Fund.

Children with Lead Poisoning

DEFINITION

Children with lead poisoning is the percentage of three-year-old-children screened for lead poisoning who had elevated blood lead levels (≥10 ug/dL) at any time prior to November 30, 2000. These data are for children eligible to enter kindergarten in the Fall of 2002 (i.e. born between September 1, 1996 and August 31, 1997).

SIGNIFICANCE

Childhood lead poisoning is one of the most common pediatric health problems, yet is entirely preventable. Infants, toddlers, and pre-school age children are most susceptible to the toxic effects of lead and absorb lead more readily than adults.[1] Lead's effects on the developing central nervous system may be irreversible.[2] Learning disabilities, hyperactivity, antisocial behavior, attention deficit disorder, stunted growth, hearing and speech impediments, and loss of intelligence can be attributed to lead levels equal to or greater than 10 ug/dL.[3,4] Higher levels of lead exposure can result in serious health problems and can lead to coma, convulsions, and death.[5]

Decreased academic performance has been linked to lead exposure during early childhood.[6] Children with lead exposure are more likely to have lowered IQ and behavioral problems, resulting in academic failure, need for special education services, and increased risk for juvenile delinquency.[7,8] While all children are at risk for lead poisoning, low-income children and minority children are particularly likely to be affected.[9,10] The lack of affordable housing in many communities forces many low-income families to live in older dwellings with deteriorating lead paint, placing children at risk for exposure to lead from lead-based paint chips and lead-contaminated dust and soil.[11,12] Inadequate nutrition and anemia, which are more common in low-income children, further increase susceptibility to lead poisoning.[13]

Because children may not display obvious symptoms of lead exposure, the best way to detect the condition is by screening with a blood test.[14,15] The Childhood Lead Poisoning Prevention Act of 1991 requires regular lead screening for all Rhode Island children under age 6.[16] The Centers for Disease Control and Prevention recommends a multidisciplinary comprehensive approach to the treatment of lead poisoned children, including repeat blood tests to monitor lead levels, medical management, house inspections, removal of lead hazards, child development services, social services, and parent education.[17,18]

Lead Exposure in Children under Age 6, Rhode Island and Core Cities, Screened between January 1, 2000 and December 31, 2000

	NUMBER SCREENED	NUMBER WITH ELEVATED LEAD LEVELS (≥10 UG/DL)	NUMBER WITH ELEVATED LEAD LEVELS (≥20UG/DL)	PERCENT WITH ELEVATED LEAD LEVELS (≥10 UG/DL)
Central Falls	1,122	210	40	19%
Providence	7,750	1,413	280	18%
Newport	828	114	11	14%
Woonsocket	1,829	235	45	13%
Pawtucket	2,768	294	46	11%
Core Cities	14,297	2,266	422	16%
Rhode Island	33,963	3,313	663	10%

◇ In 2000, more than two-thirds (68%) of children screened with high lead levels lived in the core cities. Of the 3,313 children with high lead levels statewide, 663 had very high lead levels over 20 ug/dL.

◇ Nearly one in five children screened in Central Falls and Providence in 2000 had high lead levels, compared to one in ten statewide.

◇ Nine children were hospitalized with severe lead poisoning in 2000. Of these, 1 lived in Central Falls, 2 lived in Pawtucket, and 6 lived in Providence, including a child who was hospitalized twice.[19]

Source: RI Department of Health, Office of Occupational and Radiological Health and Division of Family Health. Data are for all children screened between January 1, 2000 and December 31, 2000 (n=33,963). Communities may vary in the percentage of children under age 6 who are screened.

Lead Poisoning in Children Entering Kindergarten

◇ In the core cities, 45% percent of children entering kindergarten in the Fall of 1996 had a history of blood lead levels over 10 ug/dL as compared to 21% of children entering kindergarten in the Fall of 2002. The core cities continue to have three times as many children entering kindergarten with a history of lead exposure as the rest of the state.[20]

Table 14

Lead Poisoning in Children Entering Kindergarten in the Fall of 2002

CITY/TOWN	NUMBER TESTED FOR LEAD POISONING	# SCREENED POSITIVE >=10 UG/DL	% CHILDREN >=10 UG/DL
Barrington	214	8	3.7%
Bristol	231	20	8.7%
Burrillville	181	25	13.8%
Central Falls	384	95	24.7%
Charlestown	67	6	9.0%
Coventry	377	23	6.1%
Cranston	806	70	8.7%
Cumberland	388	15	3.9%
East Greenwich	154	6	3.9%
East Providence	546	61	11.2%
Exeter	64	3	4.7%
Foster	50	1	2.0%
Glocester	89	8	9.0%
Hopkinton	85	7	8.2%
Jamestown	41	5	12.2%
Johnston	291	13	4.5%
Lincoln	271	18	6.6%
Little Compton	34	2	5.9%
Middletown	147	15	10.2%
Narragansett	186	9	4.8%
Newport	299	55	18.4%
New Shoreham	13	2	15.4%
North Kingstown	337	14	4.2%
North Providence	311	16	5.1%
North Smithfield	114	4	3.5%
Pawtucket	1114	155	13.9%
Portsmouth	179	9	5.0%
Providence	2,998	708	23.6%
Richmond	65	4	6.2%
Scituate	147	6	4.1%
Smithfield	174	3	1.7%
South Kingstown	303	21	6.9%
Tiverton	152	11	7.2%
Warren	141	11	7.8%
Warwick	925	61	6.6%
Westerly	99	16	16.2%
West Greenwich	72	5	6.9%
West Warwick	375	28	7.5%
Woonsocket	804	142	17.7%
Unknown Residence	*457*	*32*	*NA*
Core Cities	*5,599*	*1,155*	*20.6%*
Remainder of State	*7,632*	*558*	*7.3%*
Rhode Island	*13,688*	*1,713*	*12.5%*

Source of Data for Table/Methodology

Rhode Island Department of Health, Office of Occupational and Radiological Health and Division of Family Health, December 2000.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

Data for children entering kindergarten in the Fall of 2002 reflects the number of RI children eligible to enter school in the Fall of 2002 (i.e. born between 9/1/96 and 8/31/97) who screened positive for lead poisoning at any time prior to December 2000. Rhode Island law requires universal lead screening for children under six. Lead screening results for close to 100% of Rhode Island children in this age cohort are included in this indicator.

The denominator is the number of children entering school in the Fall of 2002 who were screened for lead poisoning.

References for Indicator

1,2,3,4 *Protect Your Family From Lead In Your Home* (1999). Washington, DC: Environmental Protection Agency, United States Consumer Product Safety Commission, United States Department of Housing and Urban Development.

2,3,5,6,7,8 *Screening Young Children for Lead Poisoning: Guidance for State and Local Public Health Officials* (November 1997). Atlanta, GA: Centers for Disease Control and Prevention.

3 Pueschel, S.M., Linakis, J.G., and Anderson, A.C. (1996). *Lead Poisoning in Childhood*. Baltimore, MD: Paul H. Brookes Publishing Co.

4,6,11 *EPA Fact Sheet: Standards to Identify Dangerous Levels of Lead* (1998). Washington, DC: Environmental Protection Agency.

5 *CDC's Lead Poisoning Prevention Program* (2000). Atlanta, GA: Centers for Disease Control and Prevention.

6,8 *Coordinating Care from Clinic to Community: Quality Standards for Serving Children and Families Affected by Environmental Lead Hazards* (1998). Boston, MA: New England Serve.

7,10 *Lead Poisoning: Federal Health Care Programs Are Not Effectively Reaching At-Risk Children* (1999). Washington, DC: United States General Accounting Office.

9,11 Alliance to End Childhood Lead Poisoning Web Site: www.aeclp.org/2/ (January 2001).

10 Rhode Island General Law Chapter 23-24.6: Lead Poisoning Prevention Act, Section 8: Screening prior to child care or school enrollment.

11 Rhode Island Department of Health, Division of Occupational and Radiological Health and Division of Family Health, January 1, 2000 through December 31, 2000

12 RI Department of Health, Office of Occupational and Radiological Health and Division of Family Health. Data are for children entering kindergarten in the Fall of 1996 and 2002.

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Children with Asthma

DEFINITION

Children with asthma is the annual number of hospitalizations for asthma among children under age 18. Data are reported by place of child's residence at the time of hospitalization.

SIGNIFICANCE

Asthma is a chronic breathing disorder that causes recurrent episodes of wheezing, breathlessness, chest tightness, and cough and can be life threatening.[1,2] Asthma can be triggered by exposure to cigarette smoke, mold and dust in the home, stress, strenuous exercise, allergies, roach infestation, animal dander, indoor and outdoor pollutants, and weather conditions.[3,4,5] Childhood asthma in the U.S. increased from 40 per 1,000 children in 1982 to 65 per 1,000 children in 1998.[6]

Asthma is the number one chronic condition in children and the first ranked cause of hospitalization in children under 15.[7] In 1999 in Rhode Island, 23% of all child hospitalizations were for respiratory-related reasons; of these, more than one-quarter were for asthma.[8] Asthma is the leading cause of school absences resulting from chronic illness.[9] Black and Hispanic children are more likely to suffer from asthma. Racial differences in the prevalence of asthma are correlated with poverty, urban air quality, indoor allergens, and lack of patient education and adequate medical care.[10,11]

Managing asthma requires a long-term, multifaceted approach, including patient education, behavior modification, avoidance of asthma triggers, medication to minimize and prevent symptoms, prompt treatment, and frequent medical follow-up.[12,13] Low-income and uninsured children are more likely to receive asthma treatment in the emergency department or be hospitalized for asthma that could have been managed with appropriate outpatient care.[14]

Childhood Asthma Hospitalization Rates, Core Cities and Rhode Island, 1999

City/Town	Number of Children Hospitalized	Rate per 1,000 Children
Providence	154	4.1
Central Falls	17	3.7
Woonsocket	36	3.6
Pawtucket	43	2.7
Newport	11	2.0
Core Cities	261	3.6
Rhode Island	382	2.1

Source: Rhode Island Department of Health, Hospital Discharge Database, 1999. Data are for Fiscal Year 1999, from October 1, 1998 to September 30, 1999.

Asthma Hospitalizations, Rhode Island Children Under Age 18, October 1, 1998 to September 30, 1999

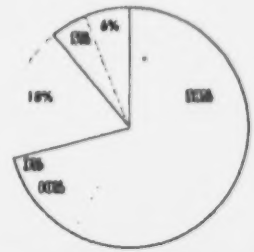
By Age

52% Birth to Age 4
34% Ages 5 to 12
14% Ages 13 to 17

n=509

By Race/Ethnicity

58% White
10% Black
3% Asian
18% Hispanic
5% Other
6% Unknown



Source: Rhode Island Department of Health, Hospital Discharge Database, 1999. Data are for Fiscal Year 1999, from October 1, 1998 to September 30 1999. Data include seven child hospitalizations of non-RI residents.

◇ In Rhode Island in 1999, more than half (52%) of all hospitalizations for childhood asthma were children under age 5. Almost one-third (31%) of all asthma hospitalizations of children under age 18 were Black, Asian, or Hispanic children.[15]

◇ In Rhode Island in 1999, 52% of all hospitalizations for childhood asthma were children residing in the core cities of Providence, Woonsocket, Pawtucket, Newport, and Central Falls, which also have the highest child poverty rates in the state.[16]

◇ Most cases of childhood asthma can be managed by the child's primary care physician. Access to timely medical care can prevent severe asthma attacks. Hospitalization for asthma may indicate that the child has not had adequate outpatient management of the disease.[17,18]

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Table 15.

Asthma Hospitalizations for Children, Rhode Island, 1999

CITY/TOWN	ESTIMATED NUMBER OF CHILDREN UNDER 18	NUMBER OF ASTHMA HOSPITALIZATIONS	RATE/1000 CHILDREN
Barrington	3,896	3	0.8
Bristol	4,317	4	0.9
Burrillville	4,215	5	1.2
Central Falls	4,603	17	3.7
Charlestown	1,795	3	1.7
Coventry	7,682	7	0.9
Cranston	14,079	29	2.1
Cumberland	6,338	4	0.6
East Greenwich	2,653	5	1.9
East Providence	10,351	17	1.6
Exeter	1,672	0	0
Foster	1,175	1	0.9
Glocester	2,257	0	0
Hopkinton	2,035	1	0.5
Jamestown	1,228	0	0
Johnston	5,294	6	1.1
Lincoln	3,918	9	2.3
Little Compton	701	0	0
Middletown	4,487	13	2.9
Narragansett	3,206	6	1.9
Newport	5,437	11	2.0
New Shoreham	178	0	0
North Kingstown	6,809	15	2.2
North Providence	5,641	14	2.5
North Smithfield	2,088	2	1.0
Pawtucket	16,093	43	2.7
Portsmouth	4,387	4	0.9
Providence	37,195	154	4.1
Richmond	1,610	4	2.5
Scituate	2,635	2	0.8
Smithfield	3,958	4	1.0
South Kingstown	5,152	8	1.6
Tiverton	2,988	1	0.3
Warren	2,487	3	1.2
Warwick	18,811	21	1.1
Westerly	5,666	8	1.4
West Greenwich	1,147	1	0.9
West Warwick	6,696	15	2.2
Woonsocket	10,101	36	3.6
Unknown Residence	-	*26*	-
Core Cities	*73,429*	*261*	*3.6*
Remainder of State	*151,552*	*215*	*1.4*
Rhode Island	*224,981*	*502*	*2.1*

Source of Data for Table/Methodology

Rhode Island Department of Health, Hospital Discharge Database, 1999. Data are for Fiscal Year 1999, from October 1, 1998 to September 30, 1999.

Core cities are Providence, Woonsocket, Pawtucket, Newport, and Central Falls.

The denominator is the total number of children under age 18 in 1999 according to Geolytic estimates using data from the U.S. Bureau of the Census, 1990 Census of Population.

See methodology on page 110 for additional information on Geolytic estimates.

References for Indicator

[1] *Guidelines for the Diagnosis and Management of Asthma* (1997). Bethesda, MD: National Institute of Health.

[2,3,17] *Asthma and the Environment: A Strategy to Protect Children* (2000). Washington, DC: President's Task Force on Environmental Health Risks and Safety Risks to Children.

[3,15] *Childhood Asthma* (1997). Milwaukee, WI: American Academy of Allergy, Asthma, and Immunology; and, *Asthma Prevention Program At-A-Glance* (1999). Atlanta, GA: Centers for Disease Control and Prevention, National Center for Environmental Health.

[4] Vanderslice, R. and Bibeault, L. (July 1999). "Asthma and the Environment: A Physician's Guide to Resources, Research, and Data" in *Medicine and Health/Rhode Island*, Vol. 82, No. 7. Providence, RI: Rhode Island Medical Society.

[6,7,9] *Asthma in Children Fact Sheet* (1999). New York, NY: American Lung Association.

[8,13,18] Rhode Island Department of Health, Hospital Discharge Database, 1999. Data are for Fiscal Year 1999, from October 1, 1998 to September 30, 1999.

[10] Asthma and Allergy Foundation of America Web site: www.aafa.org/asthmaandallergyinformation/aboutasthmaandallergies/factsandfigures/asthma_facts.cfm (November 2000).

[11] *Asthma: A Concern for Minority Populations* (1996). Bethesda, MD: National Institute of Allergy and Infectious Disease.

[12,14] *Pediatric Asthma: Promoting Best Practice – Guide for Managing Asthma in Children* (1999). Washington, DC: American Academy of Allergy, Asthma, and Immunology.

[16] *Health Insurance Coverage Leads to Increased Health Care Access for Children* (1997). Washington, DC: Government Accounting Office.

Births to Teens

DEFINITION

Births to teens is the number of births to teen girls ages 15 to 17 per 1,000 teen girls. Data are reported by the mother's place of residence, not the place of the infant's birth.

SIGNIFICANCE

Teen pregnancy and parenting threatens the development of teen parents as well as their children. Teen mothers are less likely to obtain adequate prenatal care and are less likely to have the financial resources, social supports and parenting skills needed for healthy child development.[1,2] Children born to teen parents are more likely to suffer poor health, experience learning and behavior problems, live in poverty, go to prison, and become teen parents themselves.[3]

While teen pregnancy occurs in families of all income levels, teens who give birth are more likely to come from economically disadvantaged families and communities.[4] In the U.S., 83% of teens who give birth and 61% of teens who have abortions are from poor or low-income families.[5] Teen moms are more likely to have mothers who have completed fewer years of schooling and to have mothers or older sisters who also gave birth as adolescents.[6]

Poor academic achievement is a key predictor of teen pregnancy.[7,8] Nationally, three out of five teen mothers drop out of school.[9] Being a teen parent seriously limits subsequent education and employment prospects.[10] Teen parents are more likely to delay or not finish school, putting them at greater risk of facing unemployment, low-wage jobs, and poverty.[11]

Since 1991, the teen birth rate in the United States has declined.[12] The rate of teen pregnancy reached a record low in 1999 of 49.6 births per 1,000 teen girls ages 15 to 19.[13] Research suggests that this decrease is due to fewer teens having sex, and among those who are, a greater use of contraceptives.[14]

In Rhode Island between 1995 and 1999, there were 130 babies born to girls age 12 to 14 and 2,351 babies born to girls age 15 to 17. Between 1995 and 1999 in Rhode Island, 60% of teen pregnancies resulted in live births, 37% resulted in abortion, and 3% resulted in miscarriage.[15] Over the past decade, the teen birth rate for Rhode Island girls ages 15 to 17 has decreased from 29.7 births per 1,000 teen girls to 27.2 births per 1,000 teen girls. The birth rate for Hispanic teens and Asian teens has increased during the same time period, while the birth rate for White teens and Black teens has decreased.[16]

Drop-Out Rates and Teen Pregnancy

◇ In 1998 in the U.S., almost 60% of teens who had a school-age pregnancy dropped out at some point between the 8th and 12th grades. More than a quarter of these teen mothers (28%) dropped-out before they were pregnant. An additional 30% dropped out of school after learning of their pregnancy. The other 42% remained in school.[17]

◇ Nationally, Hispanic teens are more likely than Black, non-Hispanic or White, non-Hispanic teens to drop-out prior to becoming pregnant.[18] The birth rate for Hispanic teens ages 15 to 17 in Rhode Island is more than four times the overall rate for all racial and ethnic groups in Rhode Island.[19]

◇ Receiving less than 12 years of a formal education not only limits personal and professional opportunities for young women, but also has negative effects on babies born to mothers who drop-out.[20]

Repeat Births to Teens, Ages 15 to 19, Rhode Island, 1995-1999

Age	Total Number of Births to Teens	Number of Repeat Births to Teens	Percent
15	381	14	3.7%
16	770	65	8.4%
17	1,200	185	15.4%
18	1,815	387	21.3%
19	2,187	648	29.6%
Total	6,353	*1,299*	*20.4%*

Source: Rhode Island Department of Health, Maternal and Child Health Database, Birth Files, 1995-1999. Data for 1996-1999 are provisional.

◇ In Rhode Island between 1995 and 1999, one in five births to teen girls ages 15 to 19 were births to girls who had already given birth at least once. Of all births to girls ages 15 to 17, 11% were repeat births. Of all births to girls ages 18 and 19, 26% were repeat births.[21]

◇ Rhode Island's rate of repeat births to teens ranks 19th in the country.[22]

Table 16.

Births to Teens, Ages 15-17, Rhode Island, 1995-1999

CITY/TOWN	# OF TEEN GIRLS AGES 15-17	# OF BIRTHS TO TEENS AGES 15-17	RATE PER 1,000 TEENS
Barrington	1,410	3	2.1
Bristol	1,845	26	14.1
Burrillville	1,605	18	11.2
Central Falls	1,545	89	57.6
Charlestown	485	14	NA
Coventry	3,065	47	15.3
Cranston	5,685	94	16.5
Cumberland	2,740	28	10.2
East Greenwich	1,360	5	3.7
East Providence	4,320	68	15.7
Exeter	585	5	8.5
Foster	450	4	NA
Glocester	1,030	5	4.9
Hopkinton	670	14	20.9
Jamestown	400	1	NA
Johnston	2,225	22	9.9
Lincoln	1,610	12	7.5
Little Compton	255	2	NA
Middletown	1,470	20	13.6
Narragansett	1,020	13	12.7
Newport	1,950	65	33.3
New Shoreham	25	0	NA
North Kingstown	2,385	21	8.8
North Providence	2,575	32	12.4
North Smithfield	1,165	10	8.6
Pawtucket	6,430	248	38.6
Portsmouth	1,710	13	7.6
Providence	13,395	996	74.4
Richmond	510	10	19.6
Scituate	1,080	4	3.7
Smithfield	1,430	6	4.2
South Kingstown	1,830	27	14.8
Tiverton	1,405	16	11.4
Warren	910	16	17.6
Warwick	7,275	106	14.6
Westerly	1,785	3	1.7
West Greenwich	365	56	NA
West Warwick	2,400	42	17.5
Woonsocket	3,995	190	47.5
Core Cities	*27,315*	*1,588*	*58.1*
Remainder of State	*59,080*	*763*	*12.9*
Rhode Island	*86,395*	*2,351*	*27.2*

Source of Data for Table/Methodology

Rhode Island Department of Health, Maternal and Child Health Database, Birth Files, 1995-1999. Data for 1996–1999 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

NA: Rates were not calculated for cities and towns with fewer than 100 births, as rates for small denominators are statistically unreliable.

The denominator is the number of girls ages 15 through 17 according to the 1990 Census of Population, multiplied by five to compute a rate over five years, 1995-1999.

References for Indicator

[1] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[2,3] *The Right Start: Conditions of Babies and their Families in America's Largest Cities. Kids Count Special Report* (2000). Baltimore, MD: The Annie E. Casey Foundation.

[3] *The State of America's Children Yearbook 2000* (2000). Washington, DC: Children's Defense Fund.

[4,5,7,11,12,13] *When Teens Have Sex: Issues and Trends. Kids Count Special Report* (1999). Baltimore, MD: The Annie E. Casey Foundation.

[5] *Facts in Brief: Teen Sex and Pregnancy* (1997). New York: Alan Guttmacher Institute.

[6] *Why the Education Community Cares About Preventing Teen Pregnancy: Notes from the Field* (1998). Washington, DC: The National Campaign to Prevent Teen Pregnancy.

[8,9,10] *Trends in the Well-Being of America's Children and Youth: 2000* (2000). Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[9,10,14,15] Rhode Island Department of Health, Maternal and Child Health Database, Birth Files, 1995-1999. Data for 1996-1999 are provisional.

[11,12,13] Manlove, J. (1998). "The Influence of High School Dropout and School Disengagement on the Risk of School-Age Pregnancy" in the *Journal of Research on Adolescence*, 8(2), 187-220. Lawrence Erlbaum Associates, Inc.

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Alcohol, Drug, and Cigarette Use by Teens

DEFINITION

Alcohol, drug and cigarette use by teens is the percentage of seventh-grade, ninth-grade, and twelfth-grade students who have used alcohol or marijuana in the past month or are current smokers, based on the *1998 Rhode Island Adolescent Substance Abuse Survey.*

SIGNIFICANCE

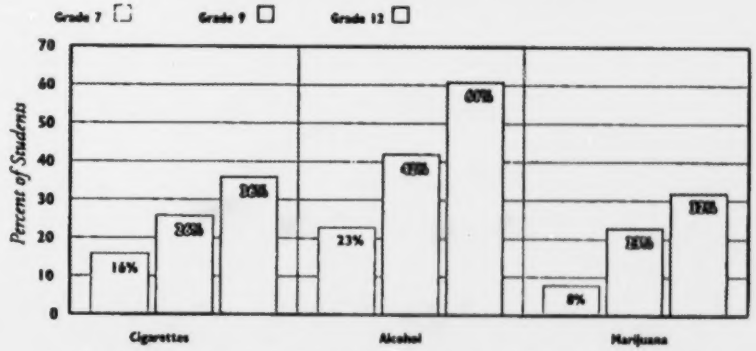
The use of substances threatens the health and safety of children, families, and communities. Children and teens are negatively affected by the emotional and financial hardships caused by parents with substance abuse problems.[1] Eighteen percent of Rhode Island seventh to twelfth graders surveyed in 1998 reported that the drinking of one or both of their parents caused problems.[2] Abuse of alcohol and drugs is implicated in unemployment, worker absenteeism, accidents, vandalism, fires, damaged and destroyed playgrounds and housing, violent crimes, poverty, and homelessness.[3]

Substance use has been shown to cause dependency, mood changes, impaired judgment, memory loss, and prolonged aimlessness.[4] Young people who abuse alcohol and drugs are more likely to drop out of school, become teen parents, engage in high-risk sexual behavior, experience injuries, and become involved with the criminal justice system.[5] The number of Rhode Island juvenile referrals to Family Court for alcohol and drug abuse violations in 2000 was 921. This was 11% of all offenses that were referred to Family Court in the state.[6]

The younger people start smoking cigarettes, the more likely they are to become strongly addicted to nicotine. Of adult daily smokers, 89% tried their first cigarette by age 18.[7] Smoking has serious long-term consequences, including the risk of smoking-related diseases, increased health care costs associated with treating these illnesses, and the risk of premature death. A recent study links smoking to depression in teens.[8] It is estimated that more than five million of today's underage smokers will die of tobacco-related illnesses.[9]

Certain factors in a teen's life have significant impact on teen health and well-being that cut across the lines of race, gender and class. Factors linked with increased likelihood of substance use and other high risk behaviors include amount of time spent unsupervised hanging out with friends, problems with school work, and drinking patterns of close friends.[10]

Use of Cigarettes, Alcohol, and Marijuana, by Student Grade Level, Rhode Island, 1998



Student has smoked at least one cigarette in the past month or has used alcohol or marijuana in the past month. Based on a survey of 5,644 students in seventh grade; 4,350 students in ninth grade; and 2,401 students in twelfth grade.

Source: *1998 Rhode Island Adolescent Substance Abuse Survey: Report of Statewide Results.* Rhode Island Department of Health, Office of Health Statistics.

◇ According to the *1999 National Household Survey on Drug Abuse,* 21% of Rhode Island teenagers admitted to binge drinking in the past month. Binge drinking is defined as the consumption of 5 or more drinks on the same occasion on at least one day in the past thirty days.[11]

◇ Although males were significantly more likely than females to be involved in most risky health behaviors, Rhode Island females are slightly more likely to try and use cigarettes than males in the same age group.[12,13]

◇ 32% of Rhode Island teenagers have tried marijuana at one time, and 20% reported having used marijuana in the past 30 days.[14]

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Risk-Taking Behavior and Safety

◇ Most teens who engage in one risk-taking behavior are also likely to engage in others. Risk-taking behaviors are defined as participation in activities such as fighting, weapon carrying, substance use, sexual activities and suicidal thoughts and attempts.[14,15]

◇ In Rhode Island, 26% of teenagers reported that in the last thirty days, they had ridden in a car driven by someone who had been drinking. Females were more likely to participate in this risk-taking behavior than males.[16]

◇ In Rhode Island, 19% of teenagers reported that they were involved in a physical fight in the past three months.[17]

◇ According to the *1999 Youth Risk Behavior Surveillance Survey*, 19% of U.S. teenagers seriously considered suicide. These numbers are higher for females than males, with 11% of females actually making a suicide attempt in contrast to 6% of males in the same age group.[18]

◇ Among sexually-active students nationwide, 25% had used drugs or alcohol during their most recent sexual intercourse.[19]

Reducing Teen Risk-Taking Behavior

◇ Preventing substance abuse, smoking and other adolescent risk behaviors requires an approach that starts before the teen years and helps children and young adolescents develop critical life skills and supportive relationships.[20]

◇ Critical life skills for teens include problem solving, decision-making, resolving conflict non-violently and coping with stress. Close and ongoing contact with caring adults and supportive family members increases the likelihood that teens are equipped with critical life skills and reduces risk-taking behavior. Good schools, safe and supportive communities, and opportunities for academic and vocational development, community service and recreation are also critical factors.[21]

◇ Youth with strong boundaries in school, at home and in the neighborhood, with positive role models and peer influences, and with high expectations are less likely to engage in risky behavior.[22]

◇ Prevention programs which are located in settings familiar and accessible to teens, and which include peer education or support and family and community involvement are more effective in reducing risk-taking behavior.[23]

References for Indicator

[1] *America's Children at Risk: A National Agenda for Legal Action* (1993). Chicago: American Bar Association.

[2,3,4,5,6,7] *1998 Rhode Island Adolescent Substance Abuse Survey: Report of Statewide Results* (1999). Providence, RI: Rhode Island Department of Health.

[3] *1996 National Survey of American Attitudes and Substance Abuse II* (1996). New York: National Center on Addiction and Substance Abuse, Columbia University.

[4] *Sex and America's Teenagers* (1994). New York: Alan Guttmacher Institute.

[5] Perry, C.L. (1996). "Models for Effective Prevention" in *The Prevention Researcher*, Vol.3, No.1 (Winter, 1996).

[6] Rhode Island Family Court, RIJIS Intake Statistics, January 1 - December 31, 2000.

[7] *Preventing Tobacco Use Among Young People: A Report of the Surgeon General* (1994). Atlanta: Centers for Disease Control and Prevention.

[8] Goodman, Elizabeth and J. Capitman (October 2000). "Depressive Symptoms and Cigarette Smoking Among Teens" in *Pediatrics*, Vol. 106, No. 4.

[9] *America's Children: Key National Indicators of Well-Being* (1999). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[10] Brahring, T., Blum R., and Rinehart, P. (2000) *"Protecting Teens: Beyond Race, Income and Family Structure."* Minneapolis, MN: The Center for Adolescent Health, University of Minnesota.

[11] *Summary of Findings from the 1999 National Household Survey on Drug Abuse* (2000). Rockville, MD: Department of Human Services, Substance Abuse and Mental Health Services Administration.

[12,13,14] "Youth Risk Behavior Surveillance- United States, 1999" *CDC Surveillance Summaries*, (June 9, 2000). MMWR 2000, 49 (No. SS-5). Atlanta, GA: Centers for Disease Control and Prevention.

[15,23] Eisen, M., Pallitto, C., Bradner, C. and Bolshun, N. (2000). *"Teen Risk-Taking: Promising Prevention Programs and Approaches."* Washington, DC: The Urban Institute.

[20,21] *Great Transitions: Preparing Adolescents for a New Century* (1995). New York: Carnegie Council on Adolescent Development.

[22] *Forty Developmental Assets* (1997). Minneapolis, MN: The Search Institute.

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Additional Children's Health Issues

Childhood Immunizations

Children need to be immunized according to the Childhood Vaccination Schedule to guard against preventable diseases that can cause morbidity and mortality.[1,2] The Centers for Disease Control and Prevention recommends that 80% of all childhood vaccinations occur within the first two years of life to reduce the spread of disease before children enter early education programs.

◇ Immunization during childhood reduces the risk of later medical problems and expenses. It is estimated that every one dollar spent on immunizations saves ten dollars in later medical cost.[3]

◇ The 1999 National Vaccination Coverage Survey reported by the National Center for Heath Statistics shows that 80% of U.S. children ages 19 to 35 months were immunized.[4]

◇ While White infants and toddlers ages 19 to 35 months have higher rates of vaccination than do their Black and Hispanic counterparts, the national disparity in vaccination narrows over time and is nearly even as children enter preschool.[3]

◇ Children who do not receive vaccines, whether it is due to a lack of access and/or parental knowledge, or a conscious decision on the part of a parent, can potentially contribute to a recurrence of vaccine-preventable diseases. As the number of individuals within a community who are not protected by immunization increases, the level of community protection from diseases decreases.[5]

Childhood Immunizations in Rhode Island

◇ In 1999, Rhode Island's immunization rate was 90%. Rhode Island ranked second best in the nation.[7]

◇ Although vaccination levels in the U.S. and R.I. have been substantially increasing and racial and ethnic disparities in vaccination decreasing, children in households below the poverty level are still less likely to receive recommended vaccinations.[8]

◇ Retrospective surveys conducted by the Rhode Island Department of Health reveal significant discrepancies in the completeness of immunizations between children in low-income communities and the rest of the state. These discrepancies appear as early as three months of age, widen by seven months, and persist throughout the first two years of life.[9]

◇ In 1992, in an effort to raise immunization levels, the state of Rhode Island enacted a law that taxes insurance companies and HMOs on premiums written to subsidize vaccine costs. The money assessed is used to purchase vaccines.[10]

References

[1,2] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation of New York.

[3,4] *Trends in the Well-Being of America's Children & Youth: 2000* (2001). Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary of Planning and Evaluation.

[4] National Center for Health Statistics (2000). *National, State, and Urban Area Vaccination Coverage Levels Among Children Aged 19 to 35 Months*, United States, 1999. Washington, DC: National Immunization Program, CDC.

[5] *Victims of Our Own Success: Will Immunization Remain the Paradigm of Effective Prevention?* (2000). Washington, DC: Grant Makers in Health.

[7] Rhode Island Department of Health, Immunization Program, 1999.

[8] "Childhood Immunizations: States Tackle Costs, Education, Disparities" in the *National Conference for State Legislatures: State Health Notes* (October 2000), Vol. 21, No. 335. Washington, DC: National Conference of State Legislatures.

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Breastfeeding Promotes Child Health and Development

◇ The American Academy of Pediatrics (AAP) identifies breastfeeding as the ideal method of feeding and nurturing infants and recognizes breastfeeding as primary in achieving optimal infant and child health, growth and development.[1]

◇ Breastfeeding not only provides optimal nutrition for the newborn, it also decreases the incidence of diarrhea, lower respiratory infections and ear infections. Breastfeeding has been linked to possible decreases in Sudden Infant Death Syndrome, diabetes, allergies, lymphoma and other illnesses, and to improved cognitive development and school performance in children, improved maternal health, and reduced incidence of child abuse.[2,3]

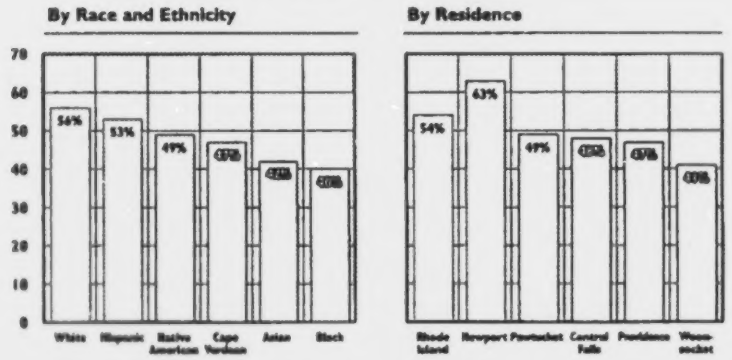
◇ Breastfeeding provides significant social and economic benefits including reduced cost to the family, reduced health care costs, and reduced employee absenteeism.[4] The AAP recommends exclusive breastfeeding for approximately 6 months after birth and, in conjunction with appropriate solid foods, for at least 12 months after birth, and thereafter as long as mutually desired.[5]

◇ Nationally, the highest rates of breastfeeding, as measured by initiation in the hospital, occur among women who are White or Hispanic, older (over age 30), higher-income and college-educated. The lowest rates of breastfeeding occur among women who are Black, are younger than 20 years old, have low educational attainment, work full-time, and/or participate in the WIC program.[6,7]

◇ Breastfeeding can be effectively promoted by health professionals through prenatal and postnatal education of the mother, physician support, hospital policies that promote early and exclusive breastfeeding and provide ongoing lactation consultation, timely postpartum follow-up care and home health visits, and links to support networks and resources.[8,9]

◇ Public policies and employer policies which promote breastfeeding are important for working women to succeed in breastfeeding. Paid maternity leave, on-site child care, opportunities during the day to nurse or express milk in a private setting, flexible work hours, job sharing and other "family friendly" policies can assist women who return to work to continue breastfeeding.[10] Rhode Island is one of five states which provide Temporary Disability Insurance payments for women who give birth.

Breastfeeding Rates in Rhode Island



◇ Between 1995 and 1999, the breastfeeding rate in Rhode Island (exclusive breastfeeding at time of hospital discharge) was 54%.[11] Six months after discharge from the hospital, only 29% of infants were still being breastfed.[12] Breastfeeding rates in Rhode Island—as in the nation as a whole—vary significantly by race, ethnicity and socioeconomic status.[13,14]

Source: Rhode Island Department of Health, Newborn Developmental Risk Assessment Screening. Breastfeeding rates for 61,088 Rhode Island women who gave birth between 1995 and 1999. Breastfeeding is defined here as breastfeeding exclusively at the time of hospital discharge.

References

1,2,3,4,5,10 "Breastfeeding and the Use of Human Milk – AAP Policy Statement" *Pediatrics*, Vol. 100, No.6 (December 1997). Elk Grove, IL: American Academy of Pediatrics.

8,9 Wright, N. (Spring/Summer 2000). "Breastfeeding and Early Childhood Development: Strategies for Proposition 10 Implementation" in *Breastfeeding: Best for Baby and Mother* (Newsletter), Vol. 2. Elk Grove Village, IL: Division of Community and Health Services, American Academy of Pediatrics.

11,12,13 *"Mother's Survey: Breastfeeding Trends Through 1999* (2000). Ross Products Division, Abbott Laboratories.

6,14 Rhode Island Department of Health, Newborn Developmental Risk Assessment Screening, 1995-1999.

7 *Ten Steps to Support Parents' Choice to Breastfeed Their Baby* (1999). Elk Grove, IL: American Academy of Pediatrics.

9 *Breastfeeding: Foundation for a Healthy Future* (2000). New York, NY: UNICEF.

Safety

From The Way to Start a Day

By Byrd Baylor

The way to start a day
is this–

Go outside
and face the east
and greet the sun
with some kind of
blessing
or chant
or song
that you made yourself
and keep for
early morning.

Child Deaths

DEFINITION

Child deaths are the number of deaths from all causes to children ages 1 to 14, per 100,000 children. The data are reported by place of residence, not place of death.

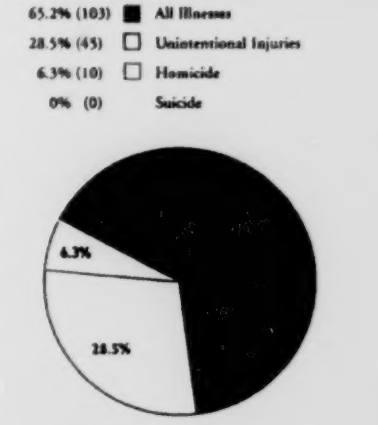
SIGNIFICANCE

The child death rate is a reflection of the physical health of children, the dangers to which children are exposed at home and in the community, and the level of adult supervision children receive.[1] Rhode Island (along with Massachusetts) has the lowest child death rate in the country.[2]

Unintentional injury is the leading cause of death for children ages 1 to 14 in Rhode Island and nationally, exceeding deaths from any single disease.[3,4] Of the 158 child deaths in Rhode Island between 1995 and 1999, 45 (28.5%) were due to unintentional injuries.[5] Fires and car accidents were the cause of 20 of these unintentional injury deaths.[6] No children ages 1 to 14 died from suicide between 1995 and 1999; in comparison, there were 7 child suicides between 1991 and 1995.

For every childhood death caused by injury, there are 34 hospitalizations, 1,000 emergency department visits, many more visits to private physicians and school nurses, and an even larger number of injuries treated at home. Nationally, 20-25% of all children sustain an injury severe enough to require medical attention, missed school, and/or bed rest.[7] Many of the injuries that do not result in death may leave children temporarily or permanently disabled, result in time lost from school, decrease the child's ability to participate in everyday activities, and affect future ability to work and be self-sufficient.[8]

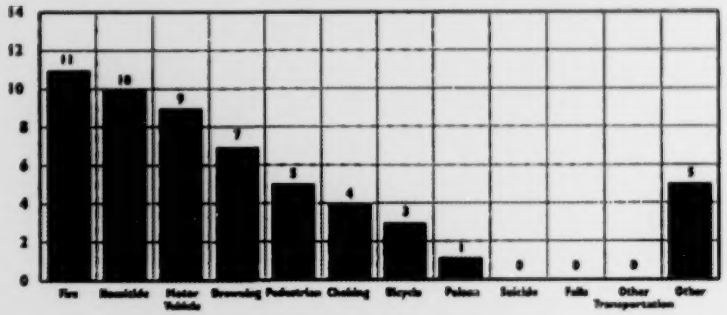
Child Deaths by All Causes, Children Ages 1 to 14, Rhode Island, 1995-1999



n=158

Source: Rhode Island Department of Health, Maternal and Child Health Database, 1995-1999. Data for 1996-1999 are provisional.

Cause of Injury Deaths, Children Ages 1 to 14, Rhode Island, 1995-1999



Cause of Injury Death (n=55)

Source: Rhode Island Department of Health, Maternal and Child Health Database, 1995-1999. Data for 1996-1999 are provisional.

◆ Motor vehicle collisions are a leading cause of injury deaths to children ages 1 to 14 in Rhode Island and nationally. Approximately 57% of the motor vehicle occupants 0-15 years old who are killed in fatal crashes are unrestrained (i.e. infants and young children who are not in properly installed car seats and older children whose seatbelts are not fastened).[9]

Childhood Injury Risk Factors and Prevention

◆ Unintentional injuries and deaths due to such injuries disproportionately affect poor children, young children, males, rural children, children in families with low levels of education and employment, and minorities.[10] In the U.S., the death rate for Black children ages 1 to 4 is more than twice that for White children.[11]

◆ The most effective injury prevention approaches are comprehensive and use multiple strategies. Effective strategies include public policy changes reinforced through safety or environmental legislation and regulation; community-based efforts to change social norms and behaviors related to safety; and individualized education, such as one-on-one counseling by a pediatrician or other health professional in a clinical setting.[12,13,14]

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Table 17.

Child Deaths, Rhode Island, 1995-1999

CITY/TOWN	NUMBER OF CHILDREN AGES 1-14	NUMBER OF CHILD DEATHS	RATE PER 100,000
Barrington	15,695	3	NA
Bristol	17,025	3	NA
Burrillville	17,930	1	NA
Central Falls	19,300	2	NA
Charlestown	6,455	0	NA
Coventry	30,045	8	NA
Cranston	57,505	5	NA
Cumberland	25,320	2	NA
East Greenwich	11,450	0	NA
East Providence	42,160	9	NA
Exeter	6,045	4	NA
Foster	4,745	1	NA
Glocester	10,145	2	NA
Hopkinton	7,445	2	NA
Jamestown	4,485	1	NA
Johnston	20,835	3	NA
Lincoln	15,265	4	NA
Little Compton	2,930	0	NA
Middletown	19,030	0	NA
Narragansett	11,390	3	NA
Newport	22,730	0	NA
New Shoreham	675	0	NA
North Kingstown	24,270	4	NA
North Providence	21,615	5	NA
North Smithfield	8,920	1	NA
Pawtucket	65,495	15	NA
Portsmouth	16,315	4	NA
Providence	151,095	33	NA
Richmond	6,345	4	NA
Scituate	9,390	0	NA
Smithfield	15,515	0	NA
South Kingstown	19,180	0	NA
Tiverton	12,140	2	NA
Warren	9,610	1	NA
Warwick	71,880	12	NA
Westerly	20,030	5	NA
West Greenwich	3,635	1	NA
West Warwick	25,840	7	NA
Woonsocket	42,310	11	NA
Core Cities	*300,930*	*61*	*20.3*
Remainder of State	*591,260*	*97*	*16.4*
Rhode Island	*892,190*	*158*	*17.7*

Source of Data for Table/Methodology

Rhode Island Department of Health, Maternal and Child Health Database, 1995-1999. Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

NA: Because nearly all cities have a low number of deaths, the death rates are highly variable, and therefore the rates are not provided for cities and towns.

The denominator is the number of children ages 1 to 14 according to the 1990 Census of Population, multiplied by five to compute a rate over five years, 1995-1999.

References for Indicator

[1] *A Data Book of Child and Adolescent Injury* (1991). Washington, DC: Children's Safety Network.

[2] *Kids Count Data Book: State Profiles of Child Well-Being 2000* (2000). Baltimore, MD: The Annie E. Casey Foundation.

[3,4] Rhode Island Department of Health, Maternal and Child Health Database, 1995-1999.

[5,6] *Childhood Injury Fact Sheet* (December 1999). Washington, D.C.: National Safe Kids Campaign.

[7] *Childhood Injury Fact Sheet* (July 1999). Washington, D.C.: National Center for Injury Prevention and Control, Center for Disease Control.

[8] Miller, T.R., Romano, E.O., Spicer, R.S. (Spring/Summer 2000). "The Cost of Childhood Injuries and the Value of Prevention" in *The Future of Children*, Vol. 10, No.1. Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[9] *Child Passenger Safety Fact Sheet* (November 2000). Washington, DC: National Center for Injury Prevention and Control, Center for Disease Control.

[10] *America's Children: Key National Indicators of Well-Being* (2000). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[11] Schieber, R., Gilchrist, J. and Sleet, D. (Spring/Summer 2000). "Legislative and Regulatory Strategies to Reduce Childhood Unintentional Injuries" in *The Future of Children*, Vol. 10, No. 1. Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[12] Klassen, T.P., MacKay, J.M., Moher, D., Walker, A., and Jones, A.L.(Spring/Summer 2000). "Community-Based Injury Prevention Interventions" in *The Future of Children*, Vol. 10, No.1. Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[13] DiGuiseppi, Roberta, I.G. (Spring/Summer 2000) "Individual-Level Injury Prevention Strategies in the Clinical Setting" in *The Future of Children*, Vol. 10, No.1. Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

Teen Deaths

DEFINITION

Teen deaths are the number of deaths from all causes to teens ages 15 to 19, per 100,000 teens. The data are reported by place of residence, not place of death.

SIGNIFICANCE

The transition to adulthood confronts teens of all ages with health and safety risks. Factors contributing to teen deaths include risk-taking behavior, the use of alcohol and drugs, and violence.[1]

The 1997 national teen death rate of 75 deaths per 100,000 teens ages 15 to 19 was nearly twice that of Rhode Island (41.8).[2,3] Nationally, the two leading causes of death for teens ages 15 to 19 are motor vehicle traffic collisions and firearm deaths.[4] Between 1985 and 1995, the risk of dying from a firearm injury more than doubled for teenagers 15 to 19 years of age.[5] In Rhode Island between 1995 and 1999, the two leading causes of teen death were motor vehicle collisions and homicide.[6]

Forty-two percent of Rhode Island teen deaths are due to unintentional injuries. Between 1995 and 1999, of the 62 teen deaths due to unintentional injuries half were due to motor vehicle collisions.[7] The *1997 Youth Risk Behavior Survey* found that – during the thirty days preceding the survey – only 24% of the teens had always used safety-belts when riding in a car; 36% had driven with someone who had been drinking alcohol; and 33% of 12th graders had driven a car when they had been drinking alcohol.[8]

More than one-quarter (29.1%) of the deaths among Rhode Island teens are due to intentional injuries (i.e. homicide or suicide). Homicide and suicide claimed the lives of 43 teens between 1995 and 1999.[9] Nationally, males ages 15 to 19 are five times more likely to die of homicide or suicide than females.[10] The death rate for male teens age 15 to 19 as a result of homicide involving firearms is almost 8 times as high for Hispanic youth and almost 19 times as high for Black youth as it is for White youth.[11] Teen White males, however, have the highest suicide rates.[12]

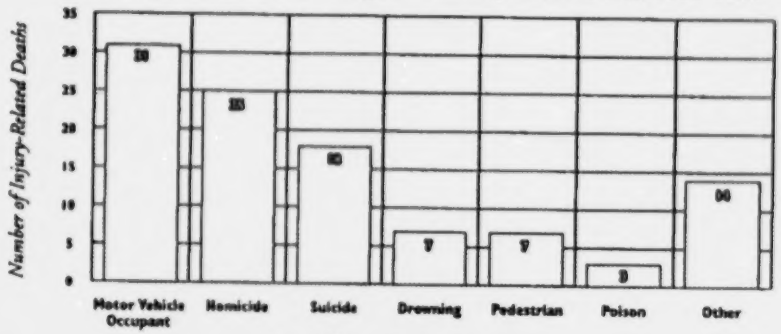
Gun Deaths Teens* Ages 15 to 19, Rhode Island, 1990-1999

YEARS	NUMBER OF DEATHS
1990-1994	29
1995-1999	22

**There were 13 gun deaths to children age 14 and younger between 1990 and 1999.*

Source: National Center for Health Statistics, Vital Statistics (1998). *Rhode Island Mortality Statistics, 1989-1994.* Rhode Island Department of Health, Office of Health Statistics, 1993-1999.

Cause of Injury Deaths, Teens Ages 15 to 19, Rhode Island, 1995-1999



Cause of Injury Death (n=105)

◇ Between 1995 and 1999, the leading causes of death due to injuries for Rhode Island teens ages 15 to 19 were motor vehicle accidents (31 deaths), homicide (25 deaths), and suicide (18 deaths). An additional 43 teen deaths were due to illnesses.

◇ In Rhode Island, the teen death rate from all causes dropped from 47.1 deaths per 100,000 teens in 1987-1991 to 41.8 deaths per 100,000 teens in 1995-1999. There were 182 teen deaths between 1987 and 1991 compared to 148 teen deaths between 1995 and 1999.

Source: Rhode Island Department of Health, Maternal and Child Health Database, 1995-1999. Data for 1996-1999 are provisional.

Gun-Related Hospitalizations, Rhode Island, 1995-1999

◇ In Rhode Island from 1995-1999, 91 children were hospitalized with gunshot wounds. Of these, 2 of the victims were younger than age five, 7 were between the ages of five and fourteen, and 80 were between the ages of fifteen and nineteen. 62 were intentional injuries, 21 were unintentional, and 8 were of undetermined intention.[13]

◇ Between 1995 and 1999, more than two-thirds (70%) of the 91 gun-related hospitalizations were Providence residents.[14]

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Table 18.

Teen Deaths, Rhode Island, 1995-1999

CITY/TOWN	NUMBER OF TEENS AGES 15-19	NUMBER OF TEEN DEATHS	RATE PER 100,000
Barrington	5,020	1	NA
Bristol	9,705	2	NA
Burrillville	5,660	3	NA
Central Falls	5,740	5	NA
Charlestown	1,640	2	NA
Coventry	10,695	6	NA
Cranston	21,325	14	NA
Cumberland	9,070	3	NA
East Greenwich	4,040	5	NA
East Providence	14,630	5	NA
Exeter	1,750	2	NA
Foster	1,445	1	NA
Glocester	3,535	2	NA
Hopkinton	2,290	0	NA
Jamestown	1,420	1	NA
Johnston	7,660	3	NA
Lincoln	5,540	4	NA
Little Compton	1,010	1	NA
Middletown	5,650	0	NA
Narragansett	3,910	2	NA
Newport	11,140	1	NA
New Shoreham	125	0	NA
North Kingstown	7,970	3	NA
North Providence	8,705	0	NA
North Smithfield	3,610	2	NA
Pawtucket	22,435	6	NA
Portsmouth	5,310	1	NA
Providence	72,915	36	NA
Richmond	1,815	1	NA
Scituate	3,430	0	NA
Smithfield	9,240	2	NA
South Kingstown	20,300	4	NA
Tiverton	5,020	1	NA
Warren	3,120	3	NA
Warwick	26,290	9	NA
Westerly	6,150	6	NA
West Greenwich	1,295	0	NA
West Warwick	8,990	5	NA
Woonsocket	14,710	4	NA
Unknown		*2*	*NA*
Core Cities	*126,940*	*52*	*41.0*
Remainder of State	*227,365*	*96*	*42.2*
Rhode Island	*354,305*	*148*	*41.8*

Source of Data for Table/Methodology

Rhode Island Department of Health, Maternal and Child Health Database, 1995-1999. Data for 1996 to 1999 are provisional.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

Because nearly all cities have a low number of deaths, the death rates are highly variable, and therefore the rates are not provided for cities and towns.

The denominator is the number of teens ages 15 to 19 according to the 1990 Census of Population, multiplied by five to calculate a rate over five years, 1995-1999.

References for Indicator

[1] *Losing Generations: Adolescents in High Risk Settings* (1993). Washington, DC: National Academy Press.

[2,4,5] *America's Children: Key National Indicators of Well-Being* (2000). Washington, DC: Interagency Forum on Child and Family Statistics.

[3,6,7,9] Rhode Island Department of Health, Maternal and Child Health Database, 1995-1999.

[5] Centers for Disease Control (July 2, 1999). "Firearm Injuries and Fatalities". Atlanta, GA: National Center for Injury Prevention and Control.

[8] *1997 Rhode Island Youth Risk Behavior Survey* (1998). Providence, RI: Rhode Island Department of Health.

[10] Centers for Disease Control (July 2, 1999). "Facts on Adolescent Injury". Atlanta, GA: National Center for Injury Prevention and Control.

[11] Centers for Disease Control (Jan. 28, 2000) "Suicide in the United States". Atlanta, GA: National Center for Injury Prevention and Control.

[10,11] Rhode Island Department of Health Hospital Discharge Database, 1995-1999.

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Homeless Children

DEFINITION

Homeless children is the number of Rhode Island children under 13 years old who received emergency housing services at emergency homeless shelters and domestic violence shelters between July 1, 1999 and June 30, 2000.

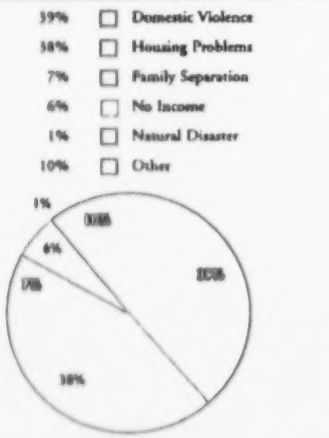
SIGNIFICANCE

Poverty, the lack of affordable housing, and domestic violence are factors in family homelessness.[1,2,3] The shortage of affordable apartments and the dwindling availability of subsidized housing have caused many Rhode Island families to "double-up", resulting in overcrowded, unstable living conditions. With a large percentage of family income going toward rent, any interruption in income or unexpected expense can place families at risk of homelessness.[4,5] Domestic violence contributes to homelessness among women with children.

In the U.S., more than 40% of the homeless are women and children – the fastest growing homeless group.[6] Homeless children are more likely to get sick, have poor nutrition, develop mental health problems, have academic problems, and experience violence than children who are not homeless.[7] Infants, toddlers and preschoolers who are homeless develop more slowly and may develop emotional problems serious enough to require professional care.[8] School-age children who are homeless face academic and emotional problems that hinder success in school.[9]

In Rhode Island in 2000, there were 1,321 children who received shelter from the emergency and domestic violence shelter system: 732 (55%) were age 5 or under, 490 (37%) were ages 6 to 12, and 99 (8%) were ages 13 to 17.[10] More than 9 out of 10 families receiving shelter were single parent families. More than 90% of families had incomes below $15,000.[11]

Reasons Families Needed Shelter, Rhode Island, 2000



n = 590 families

**Housing problems includes housing cost, legal evictions, relocations, landlord/tenant dispute, and utilities shut-off*

Source: *RI Emergency Shelter Information Project Annual Report*, July 1, 1999 – June 30, 2000 (2001). Providence, RI: RI Emergency Food and Shelter Board

Homeless Children and Exposure to Violence

◇ A 1999 study of over 2,000 homeless families found that homeless children are exposed to violence in a number of ways. Fifty-seven percent of school-aged homeless children had witnessed or been victims of violence in their homes or communities.[12]

◇ Domestic violence is a common cause of homelessness, affecting nearly two-thirds of homeless parents nationally. Children are not shielded from the abuse. Almost half of homeless school-aged children and over one-quarter of homeless children under age five had witnessed domestic violence.[13]

◇ Homeless children are exposed to violence in their communities as well. Parents report that one in three homeless teens and one in five homeless grade-schoolers had witnessed a stabbing, shooting, rape, or murder in their neighborhoods.[14]

◇ Exposure to violence harms children psychologically as well as physically. As a result of experiencing violence, school-age children are at risk for developing depression and anxiety, may display disruptive behavior, and often perform poorly in school.[15]

Emergency Shelter in Rhode Island

◇ The Emergency Shelter system in Rhode Island is at maximum capacity. Shelters that were previously available to families to provide temporary shelter are now full. An increasing number of parents and children are unable to leave the shelters because affordable housing is not available.

◇ The lack of shelter space has resulted in families and children sleeping on the floor in community spaces not designated as shelter facilities. Travelers Aid reports that children slept on the community room floor on 68 nights between June and December 2000. On many of those nights, as many as eight children shared the small space with their parents and other single adults.

Sources: *Neighborhood Opportunities Program [Factsheet]* (2000). Providence, RI: State of Rhode Island Housing Commission, and Travelers Aid of Rhode Island, Overnight Guests in Travelers Aid Community Room, June - December 2000.

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DEFINITION

Homeless youth is the number of Rhode Island youth ages 13 to 21 who are homeless or at risk for homelessness, have run away from home, or have been thrown out of their home and not allowed to return.

SIGNIFICANCE

Homelessness among youth has a number of causes, including family problems such as strained relationships and physical abuse, residential instability resulting from foster care, residential, and institutional placements, and family homelessness.[1] Some runaway youth are considered to be "throw-aways" who were told to leave a household, were abandoned or deserted, or tried to return home and were denied access.[2] Homeless youth are at risk of being physically and/or sexually victimized, abusing drugs and alcohol, attempting suicide, becoming victims or perpetrators of crime, receiving money for sex to meet their basic survival needs, and contracting HIV/AIDS.[3]

Adolescents who have supportive relationships with adults and peers are healthier and less likely to be involved in high-risk situations than those who lack such relationships. This "connectedness" is a protective factor in the lives of teens regardless of their race, ethnicity, family structure, or poverty status.[4]

Homeless/Runaway/Throwaway Youth in Rhode Island

Emergency Shelter System

◇ There were 99 youth between the ages of 13 and 17 who received shelter through the emergency shelter system between July 1999 and June 2000.[5] This is an underestimate of the number of youth in need of shelter, as many of the emergency and domestic violence shelters do not accept males over the age of twelve.

Travelers Aid

◇ Rhode Island does not have an overnight emergency shelter for runaway youth.

◇ A total of 975 youth under age 22 accessed services through Travelers Aid from January through December 1999. Of these, 253 were homeless, 326 were runaways/throwaways (under age 18) and 248 were in transitional arrangements, including treatment centers, shelters or "doubled up" with family members. The remainder (148) were considered to be at risk for homelessness.[6]

◇ Of the youth that received services in 1999 from Travelers Aid, over half had dropped out of school; 40% were uninsured; 60% were either presently or had in the past been involved with DCYF and 13% of the youth had children themselves.[7]

◇ In 1999, the Traveler's Aid Runaway Youth Project provided street outreach services to more than 5,700 youth in Providence, Pawtucket, Central Falls and Newport. Due to an end in the federal funding for this program, outreach services to these at-risk youth are no longer being provided.[8]

DCYF Night-to-Night Placements and Unauthorized Absence

◇ In 2000, an average of 27 adolescent boys and 61 adolescent girls per month were in "night-to-night placements". Night-to-night placements refer to the temporary nightly placement of youths under the care of DCYF who are awaiting permanent foster care placement, a group home/treatment placement, or who have run away from their current placement.[9]

◇ As of December 2000, there were 115 youth in DCYF care who were classified as unauthorized absence/runaways.[10]

References for Indicators

Homeless Children

[a] "Homeless Families With Children" *NCH Fact Sheet #7* (June 1999). Washington, DC: National Coalition for the Homeless.

[b,c,d] *Homeless Children: America's New Outcasts* (1999). Newton, MA: The Better Homes Fund.

[e] *A Status Report on Hunger and Homelessness in America's Cities* (2000). U.S. Conference of Mayors.

[f,g,h,i,j] *Children and Their Housing Needs: A Report to KIDS COUNT* (1993). Washington, DC: Center on Budget and Policy Priorities.

[k] *Homeless in America: A Children's Story, Part One* (1999). New York, NY: Homes for the Homeless and The Institute for Children and Poverty.

[l,m] *Rhode Island Emergency Shelter Information Project, July 1, 1999-June 30, 2000* (2001). Providence, RI: RI Emergency Food and Shelter Board.

[n] *Helping Children and Adolescents Cope with Violence and Disasters* (2000). Bethesda, MD: National Institute of Mental Health.

Homeless Youth

[1] *NCH Fact Sheet #11: Homeless Youth* (1999). Washington, DC: National Coalition for the Homeless.

[2] Schneider, D. (1995). *American Childhood: Ride and Realities*. Princeton, NJ: Rutgers University Press.

[3] *Youth with Runaway, Throwaway, and Homeless Experiences: Prevalence, Drug Use, and Other At-Risk Behaviors* (1995). Washington, DC: Family and Youth Service Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

[4] Blum, R.W. and Rinehart, P.M. (1997). *Reducing the Risk: Connections that Make a Difference in the Lives of Youth*. Minneapolis, MN: University of Minnesota, Division of General Pediatrics and Adolescent Health.

[5] Rhode Island Emergency Shelter Information Project, July 1, 1999-June 30, 2000 (2001). Providence, RI: Rhode Island Emergency Food and Shelter Board.

[6,7] Travelers Aid, Providence, RI: Year-End Reports, 1999. Updated information for 2000 not available.

[8] Rhode Island Office of the Child Advocate, December 2000.

[9] Rhode Island Department of Children, Youth and Families, December 2000.

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Juveniles Referred to Family Court

DEFINITION

Juveniles referred to Family Court is the percentage of youth ages 10 to 17 referred to Rhode Island Family Court for all wayward and delinquent offenses.

SIGNIFICANCE

Poor school performance, including chronic truancy and falling behind one or more grade levels, increases the likelihood of involvement with the juvenile justice system. Other risk factors for juvenile crime and delinquency include poverty, family violence, inadequate supervision, limited education and job skills, substance abuse, and mental health problems.[1,2,3] Most juvenile crime takes place in the after-school and early evening hours.[4]

The Rhode Island Family Court has jurisdiction over all juvenile offenders referred for wayward and delinquent offenses. All referrals to Family Court are from state and local law enforcement agencies, except for truancy cases which are referred by local school departments. Approximately one-third of all cases referred to Family Court are diverted instead of proceeding to a formal court hearing.

Juveniles who commit crimes involving drugs may be referred by the Family Court to the Juvenile Drug Court, rather than proceeding through the regular juvenile court system.[5] Juveniles referred to the Drug Court undergo a six to twelve month program that includes intensive court supervision, drug treatment, school performance reviews, job placement, and development of social skills and interests outside the drug culture.[6]

Prevention and early intervention are the most cost-effective approaches to reducing delinquency.[7] Effective prevention strategies combine programs such as truancy reduction, substance abuse services, youth mental health services, mentoring, conflict resolution, after-school tutoring, vocational training, recreation, community service and leadership development.[8,9] Programs are most effective when they are comprehensive, community-based, and culturally-appropriate.[10]

Rhode Island is one of six states participating in the implementation of the U.S. Justice Department Office of Juvenile Justice and Delinquency Prevention's (OJJDP) Comprehensive Strategy for Serious, Violent and Chronic Juvenile Offenders designed to improve the effectiveness of the juvenile justice system; provide appropriate prevention strategies for children, families, and communities; and, intervene in the lives of first-time offenders with structured programs and services.[11]

Juvenile Wayward/Delinquent Offenses Referred to Family Court, by Type of Offense, Rhode Island, 2000

31%	Property Offenses	6%	Violent Crime Offenses
16%	Status Offenses*	6%	Traffic Offenses
12%	Disorderly Conduct	2%	Weapons Offenses
12%	Simple Assaults	3%	Other**
11%	Alcohol and Drugs		

n = 8,368

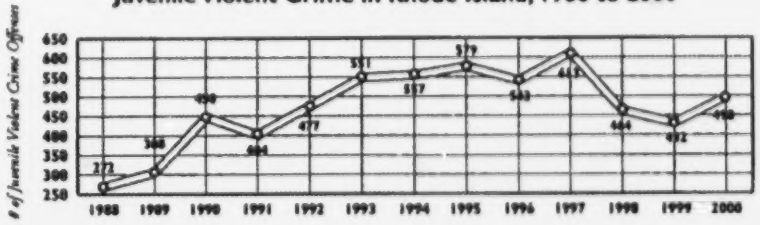
**Status Offenses are age-related acts that would not be punishable if the offender were an adult, such as truancy and disobedient conduct.*

***Other includes offenses such as false report of a crime, conspiracy, crank/obscene phone calls, and escapes from custody.*

◇ In 2000 in Rhode Island, 4,783 juveniles were referred to Family Court for 8,368 offenses. Between 1989 and 2000, the number of youth ages 10 to 17 referred to Family Court increased by 46% from 3,271 youth in 1989 to 4,783 youth in 2000. Fewer than 5% of youth ages 10 to 17 are referred to Family Court each year.

Source: Rhode Island Family Court, Juvenile Offense Reports for 1989, 1999, and 2000.

Juvenile Violent Crime in Rhode Island, 1988 to 2000



◇ In Rhode Island, the juvenile violent crime rate increased from the late 1980s to the late 1990s, peaking in 1997. The juvenile violent crime rate began to decline in 1998, and in 1999 was at its lowest level since 1991.

Source: Rhode Island Family Court, Juvenile Offense Reports, 1988 to 2000. Violent crime includes robbery, aggravated assault, homicide, and sexual assault.

Minors Taken Into Custody

◇ Minors may be taken into custody for criminal behavior, for status offenses, and for non-offense reasons (such as abuse or neglect, abandonment, or for questioning). Status offenders and non-offenders must either be released to a parent or guardian or placed in a non-secure area of the police department that is completely separated both by sight and sound from adult offenders. Criminal offenders who are placed in secure detention (such as a cell or handcuffed to a stationary object) must be released or transported to the state's juvenile facility within 6 hours of being placed in secure detention.[12]

◇ In 2000 in Rhode Island, there were 4,276 instances of youth being taken into custody for criminal behavior or status offenses. Of these, 38% occurred in the core cities of Providence, Pawtucket, Woonsocket, Newport, and Central Falls. The core cities accounted for 46% of criminal offense instances of custody and 28% of status offense custody instances.[13]

◇ Of all minors taken into custody in 2000 in Rhode Island, 66% were White, 18% were Black, 13% were Hispanic, and 3% were Asian.[14]

Juvenile Hearing Boards

◇ Cities and towns in Rhode Island may establish local Juvenile Hearing Boards to allow juveniles accused of status offenses or misdemeanors to bypass the formal court process when they are willing to admit their offense and agree to abide by the decision of the Board. Sanction options in this diversion process include community service, restitution, mental health or substance abuse counseling, and/or a community-based program.[15]

◇ There are 26 Juvenile Hearing Boards serving 28 Rhode Island communities.[16] In 2000, there were 924 referrals made to Juvenile Hearing Boards, compared to 767 in 1999. Of all youth referred to Hearing Boards in 2000, 83% were White, 9% were Black, 7% were Hispanic, 1% were Asian and 1% were other.[17]

Juveniles Tried as Adults

◇ When a juvenile has committed a heinous and/or premeditated felony offense or has a history of felony offenses, the Attorney General may request that the Family Court judge waive jurisdiction so that the juvenile may be tried as an adult in Superior Court. Waiver is mandatory for juveniles age 17 or older who are charged with murder, first degree sexual assault, or assault with intent to commit murder.[18]

◇ A juvenile may also be "certified" – allowing the court to sentence the juvenile to age 21 or beyond if there is an insufficient period time in which to accomplish rehabilitation. Until age 21, the sentence is served at the Training School; upon reaching majority the youth is transferred to an adult facility.[19]

◇ In 2000, the Attorney General's Office filed 30 Motions to Waive jurisdiction to try juveniles as adults and 5 Motions to Certify. Eleven Motions to Waive were withdrawn and nine were waived out of Family Court to adult court. There are currently 13 motions pending before the Family Court.[20]

References for Indicator

[1] *Juvenile Offenders and Victims, A National Report* (1999). Washington, DC: Office of Juvenile Justice and Delinquency Prevention, US Department of Justice.

[2] *Great Transitions: Preparing Adolescents for a New Century* (1995). New York: Carnegie Council on Adolescent Development.

[3] Bilchik, S. (July 1998). *OJJDP Fact Sheet #82.* "Mental Health Disorders and Substance Abuse Problems Among Juveniles." Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[4] Chaiken, M.R. (June 1998). *Issues and Practices in Criminal Justice: Kids, COPS, and Communities.* Washington, DC: U.S. Department of Justice, National Institute of Justice and Carnegie Corporation of New York.

[5] Rhode Island Family and Juvenile Drug Court, Newsletter, Issue 1: Winter 2000.

[6,10] *Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders* (1995). Washington, DC: Office of Juvenile Justice and Delinquency Prevention, US Department of Justice.

[8,9] *Combating Violence and Delinquency: The National Juvenile Justice Action Plan* (1996). Washington, DC: Coordinating Council on Juvenile Justice and Delinquency Prevention.

[9] Morley, E., Rossman, S.B, Kopczynski, M., Buck, J., and Gouvis, C. (2000). *Comprehensive Responses to Youth at Risk: Interim Findings From the Safe Futures Initiative.* Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[11] Smith, J.E. and Gilheeney, E. (2001). *Juvenile Standards: Guidelines for the Handling of Youthful Offenders and Non-Offenders.* Providence, RI: The Rhode Island Justice Commission.

[12,14] Rhode Island Justice Commission, Juvenile Detention Data Summary, 2000.

[13,16,17] Pirolli, R. *Juvenile Hearing Board 2000 Year-End Report* (2001). Providence, RI: Rhode Island Family Court.

[18,19] R.I. General Laws, Sections 14-1-7; 14-1-7.1; 14-1-7.2; 14-1-7.3.

[20] Rhode Island Office of the Attorney General, December 2000.

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Juveniles at the Training School

DEFINITION

Juveniles at the training school is the number of juveniles up to age 21 who were in the care and custody of the Rhode Island Training School for Youth at any time during the calendar year. The total includes youth who spent time at the Training School and/or in other community placements while in the care and custody of the Training School.

SIGNIFICANCE

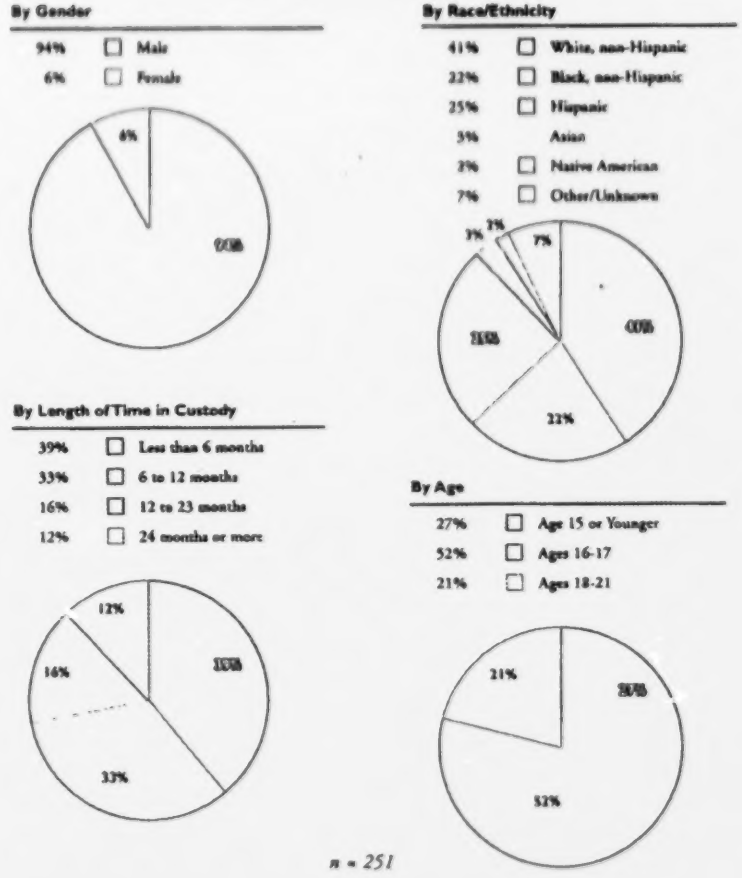
Juvenile detention facilities must balance public safety with the need for treatment and rehabilitation of young offenders.[1] If properly structured, detention can offer an opportunity for rehabilitation to troubled youth. A combination of persistent school problems, drug use, and mental health issues are associated with persistent serious delinquency of the kind likely to lead to secure incarceration.[2]

It is cost-effective to implement comprehensive community-based strategies that identify risks for youth; focus on prevention, diversion, and rehabilitation; and address reintegration into the community.[3] A graduated system of sanctions, treatment and step-down programs can minimize recidivism.[6]

Community placements can help to address the large racial disparity among incarcerated youth.[8] In 1996, secure detention was nearly twice as likely for Black youth as for Whites, even after controlling for the nature of the offense.[9] Only a fraction of incarcerated juveniles are violent and dangerous. Most youth are incarcerated for drug and property offenses that could be addressed through diversion programs.[10]

The Department of Children, Youth and Families operates the Rhode Island Training School for Youth, the state's 179-bed residential detention facility for adjudicated youth and for youth awaiting trial. There were a total of 1,017 youth in the care and custody of the Training School at some point during calendar year 2000. As of January 11, 2001 there were 180 youth on the grounds at the Training School. Of these, 27 were unadjudicated (i.e. awaiting trial). An additional 132 youth were within the care and custody of the Training School in temporary home or community placements. Eight youth were classified as runaways.[11]

Juveniles in the Care and Custody of the Rhode Island Training School for Youth, January 2001



n = 251

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), January 11, 2001. Data are for adjudicated youth only.

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Risk Factors for Involvement in the Juvenile Justice System

School Failure

◇ A survey of educational records of Training School youth confirms significant academic difficulty. Based on 84 records reviewed in October-November 2000, 65% (55) of the youth had no school records for at least one of the two years preceding detention. Of the 36 students who had any school records in the two years preceding detention, 42% (15) failed, many due to excessive absences. Another 31% (11) barely passed, with mostly Ds and Fs.[12]

Unmet Needs for Special Education and/or Mental Health Services

◇ Appropriate special education services and mental health services are critical to both prevent delinquency and assist in rehabilitation. School failure, unexcused absences, chronic disciplinary problems and grade retention may be associated with a disabling condition that has not been detected.[13]

◇ The cause of delinquent behavior may be directly related to a child's disability.[14] In the Rhode Island Training School, about 48% of adjudicated and unadjudicated students receive special education services, primarily due to learning disabilities or conduct disorders.[15] This is almost two and one-half times the rate of students receiving special education services in Rhode Island public schools in 2000.[16]

History of Child Abuse

◇ Approximately 39% (109) of the adjudicated youth within the care and custody of the Training School on December 31, 2000 had at some point in their childhood been victims in an indicated incident of child abuse or neglect.[17]

Prevention and Rehabilitation

◇ Under federal law, youth who are detained in secure facilities have a right to protection from violent inmates, abusive staff, unsanitary living conditions, excessive isolation and unreasonable restraint. Detained youth are entitled to adequate medical and mental health care, education (including special education where appropriate), access to legal counsel, and access to family communication, recreation, exercise and other programs.[18]

◇ While the law authorizes juvenile pretrial detention only if the youth poses a risk of committing a new offense or failing to appear for court, many youth are in fact detained for other reasons, including punishment, unavailability of appropriate alternative placements and lack of adequate mental health services in the community.[19]

◇ Secure pretrial detention is not a deterrent to future offenses. Minimizing pretrial detention requires collaborative planning among agencies within the juvenile justice system, objective policies and practices for secure pretrial confinement, and adequate community resources for alternative placement and supervision.[20]

References

[1,2,3,4] Puritz, P. Scali, M.A. (1998) *Beyond the Walls: Improving Conditions of Confinement for Youth In Custody.* Washington, DC: American Bar Association Juvenile Justice Center and U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[5] Huizinga, D., et.al. (November 2000). "Co-occurrence of Delinquency and Other Problem Behaviors" in *Juvenile Justice Bulletin.* Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[6] Maynard, R.A., Garry, E.M. (January 1997). *Adolescent Motherhood: Implications for the Juvenile Justice System, Fact Sheet #50.* Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[7] Garry, E. (December 1997). *Responsible Fatherhood, Fact Sheet #73.* Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[8,9,10] *Guide for Implementing the Comprehensive Strategy for Serious, Violent, and Chronic Juvenile Offenders* (1998). Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[11] *Juvenile Offenders and Victims: 1999 National Report* (September 1999). Washington, DC: U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[12,17] Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2000.

[13] Rhode Island Training School for Youth, 2000.

[15] Rhode Island Training School for Youth, February 9, 2001.

[16] Rhode Island Department of Elementary and Secondary Education, Office of Special Education, 2000.

[18,19] Rust, B. (Fall/Winter 1999). "Juvenile Jailhouse Rocked: Reforming Detention in Chicago, Portland, and Sacramento" in *ADVOCASEY.* Baltimore, MD: The Annie E. Casey Foundation.

Children Witnessing Domestic Violence

DEFINITION

Children witnessing domestic violence is the percentage of reported domestic violence incidents in which children under age 18 were present in the home. The data are based on police reports of domestic violence in 1999. Domestic violence is the use of physical force, or threat of force, against a current or former partner in an intimate relationship, resulting in fear and emotional and/or physical suffering.

SIGNIFICANCE

Domestic violence is a serious social issue that affects all communities and cuts across racial, ethnic and economic lines.[1] It is estimated that one-fifth to one-third of all women are assaulted by a partner or ex-partner during their lifetime.[2] In Rhode Island in 1999, police reports indicate that children were present in 37% (2,655) of domestic violence incidents reported.[3] National surveys of mothers indicate that 87% of children have witnessed the abuse in homes where there is domestic violence.[4]

Children who experience adult domestic violence in their homes suffer trauma even if they, themselves, are not physically harmed. They may witness their mother being abused, hear their mother's cries or a batterer's threats, and/or observe the results of a violent event through their mother's injuries or through the physical damage done to their homes.[5]

Exposure to domestic violence can limit children's cognitive development and their ability to form close attachments.[6] Children who witness domestic violence may experience anxiety, fear, sleep disruption, frequent illnesses, depression, post-traumatic stress disorder, and have problems in school.[7,8] Children who experience violence over a period of time are more likely to have serious emotional and behavioral problems, including violent behavior.[9]

Children who grow up in violent homes are much more likely to become abusive partners or victims of abuse in adolescence and/or adulthood. Over 80% of abusive partners had themselves either been victims of child abuse or had witnessed their mothers being abused.[10] Children in homes where a parent is abusive to a spouse are at increased risk of child abuse.[11]

There are six shelters and advocacy programs in Rhode Island that offer services to children who witness domestic violence. Services include therapy, individual counseling, expressive arts therapy, and child care. These shelters also offer school-based domestic violence prevention programs.[12]

Child Protection Agencies and Domestic Violence

Agencies responsible for child protection need to be active in preventing domestic violence and treating families affected by the problem. Research indicates that domestic violence is present in at least one-third of the families who are involved in child abuse and/or neglect cases. Effective strategies and policies for child protection agencies to address domestic violence include:

◇ Development of protocols that assist child protection workers in the screening of families for domestic violence and use of specific tools that guide workers as they investigate, conduct risk assessments, and engage in service planning.

◇ Commitment of resources, such as funding and staff time, to ongoing and up-to-date training for child welfare workers about domestic violence and its effects on children.

◇ Recognition that the safety of children living in homes where there is domestic violence and the safety of their battered mothers cannot be separated.

◇ Strong collaboration and cross-training between child protective services and domestic violence agencies to ensure that safety and stability are provided to the child, while support is also offered to the battered woman as she pursues safety and self-sufficiency.

Source: Findlater, J and S. Kelly (1999). "Child Protective Services and Domestic Violence" in *The Future of Children: Domestic Violence and Children*, Vol. 9, No. 3 (Winter 1999). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

Services for Women and Children

◇ In 2000, the six domestic violence agencies in Rhode Island provided services to 1,129 children. There were 363 women and 410 children who spent time in a domestic violence shelter.[13]

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Children and Domestic Violence in Rhode Island

◇ Based on police reports from cities and towns in Rhode Island between January 1, 1999 and December 31, 1999, children were present during 2,655 (37%) of the 7,145 reported cases of domestic violence. An additional 78 incidents were reported to state police; police reported that children were present at 26 of these incidents.[14]

◇ Police officers reported that in 1,921 incidents the children saw their parent being abused and in 2,259 incidents the children heard their parent being abused. These numbers are based on police reports in which the attending officer may check any combination of three boxes: Were children present during the incident? Did children witness the incident? Did children hear the incident?[15]

◇ Table 19 underrepresents the number of incidents of domestic violence in which a child was present because police reports are not fully completed in all cases. Additionally, many cases of domestic violence are never reported to police.

◇ Table 19 underestimates the total number of children who experienced domestic violence in their homes, since more than one child may be present at the incident.

Table 19

Domestic Violence Incidents with Children Present, Rhode Island, 1999

CITY/TOWN	TOTAL NUMBER OF DOMESTIC VIOLENCE INCIDENT REPORTS	TOTAL NUMBER OF INCIDENTS IN WHICH A CHILD WAS PRESENT	% OF INCIDENTS WITH CHILDREN PRESENT
Barrington	49	14	29%
Bristol	124	57	46%
Burrillville	60	20	33%
Central Falls	174	82	47%
Charlestown	52	22	42%
Coventry	192	72	38%
Cranston	397	151	38%
Cumberland	114	40	35%
East Greenwich	43	13	30%
East Providence	260	124	48%
Exeter	NA	NA	NA
Foster	10	4	40%
Glocester	49	23	47%
Hopkinton	36	18	50%
Jamestown	14	6	43%
Johnston	370	123	33%
Lincoln	62	33	53%
Little Compton	9	2	22%
Middletown	143	39	27%
Narragansett	72	19	26%
Newport	390	132	34%
New Shoreham	14	1	7%
North Kingstown	202	82	41%
North Providence	213	68	32%
North Smithfield	52	20	38%
Pawtucket	829	324	39%
Portsmouth	152	53	35%
Providence	949	305	32%
Richmond	14	10	71%
Scituate	34	16	47%
Smithfield	111	43	39%
South Kingstown	56	24	43%
Tiverton	82	19	23%
Warren	279	100	36%
Warwick	437	161	37%
Westerly	231	79	34%
West Greenwich	16	8	50%
West Warwick	328	143	44%
Woonsocket	526	205	39%
Core Cities	*2,868*	*1,048*	*37%*
Remainder of State	*4,277*	*1,607*	*38%*
Rhode Island	*7,145*	*2,655*	*37%*

Source of Data for Table/Methodology

The number of domestic violence incident reports and the number of incidents in which children were present are based on the Domestic Violence and Sexual Assault/Child Molestation Reporting Forms received by the Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit between January 1, 1999 and December 31, 1999.

References for Indicator

[14] *The Impact of Domestic Violence on Children: A Report to the President of the American Bar Association* (1994). Chicago: American Bar Association Center for Children and the Law.

[15] Osofsky, J. (1995). "Children Who Witness Domestic Violence: The Invisible Victims." *Social Policy Report: Society for Research in Child Development*, Vol. IX, No. 3.

[2,5,13] Rhode Island Supreme Court Domestic Violence Training and Monitoring Unit. Based on data from Domestic Violence and Sexual Assault/Child Molestation Reporting Forms received from police departments between January 1, 1999 and December 31, 1999.

[4] Rhode Island Coalition Against Domestic Violence (1997). "Children and Domestic Violence" (Fact Sheet).

[12] Wilson, K.J. (1997). "The Effects of Family Violence on Children," in *When Violence Begins at Home*. Hunter House Publications.

[9] National Resource Center on Domestic Violence (1999). "Problems Associated with Children's Witnessing of Domestic Violence." [Internet]

[3,10] Carter, J., et al. (1992). *Domestic Violence in Civil Court Cases: A National Model for Judicial Education*. San Francisco: The Family Violence Prevention Fund.

[11] Edleson, J. (1998) *The Overlap Between Child Maltreatment and Woman Abuse*. Minneapolis, Minnesota: Center Against Violence and Abuse.

[1,6,8] The Rhode Island Coalition Against Domestic Violence. Data for the period from January 1, 2000 through December 31, 2000.

Child Abuse and Neglect

DEFINITION

Child abuse and neglect is the total number of indicated cases of child abuse and neglect per 1,000 children. "Indicated case" means that credible evidence exists that child abuse and/or neglect occurred following an investigation of an abuse report. An indicated case can involve more than one child. Child abuse includes physical, sexual, and emotional abuse. Child neglect includes physical, emotional, educational and medical neglect.

SIGNIFICANCE

Preventing child abuse and neglect is critical to helping children grow into strong, healthy, productive adults and good parents. Children are at increased risk for maltreatment if their parents or caregivers are overwhelmed by multiple problems such as inadequate income, lack of a job or a decent place to live, emotional stress, isolation from extended family or friends, drug and/or alcohol abuse, mental illness, or domestic violence.[1] Recent studies confirm that child abuse is linked to increases in dropout rates, juvenile delinquency, running away, substance abuse, suicide, criminal behavior, emotional disturbances, promiscuity, and teenage pregnancy.[2,3,4]

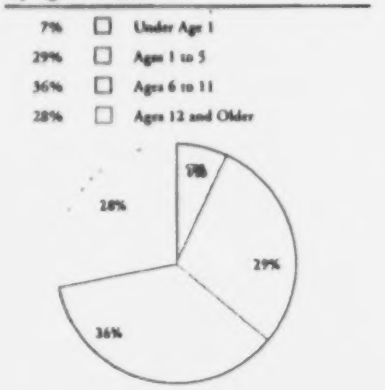
Many abusive parents lack essential parenting skills and are struggling with a combination of social and economic issues. Preventing child abuse and neglect requires help with housing, food, and child care as well as parenting education and counseling for substance abuse, domestic violence, and other problems. Families benefit from access to community-based, comprehensive services that are able to flexibly respond to their needs.[5,6]

Responding to reports of child abuse and neglect and ensuring child safety in crisis situations are important functions of child protection systems. Focusing on prevention is equally critical and frequently more cost-effective. Currently in Rhode Island more than 80% of the budget of the Department of Children, Youth and Families (DCYF) is spent on 20% of its caseload, particularly "high-end" costs such as hospitalization of children with mental health problems.[7] The absence of appropriate lower-cost placements contributes to this mismatch.[8]

In 2000, there were 2,371 indicated cases of child abuse and neglect involving 3,060 Rhode Island children.[9] Between October 1, 1998 and September 30, 1999, there were 19 children hospitalized with the diagnosis of child abuse or neglect.[10]

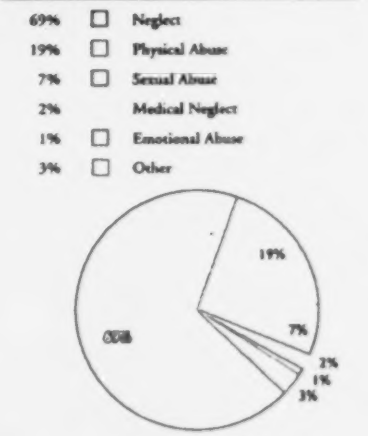
Indicated Cases of Child Abuse and Neglect, Rhode Island, 2000

By Age of Victim



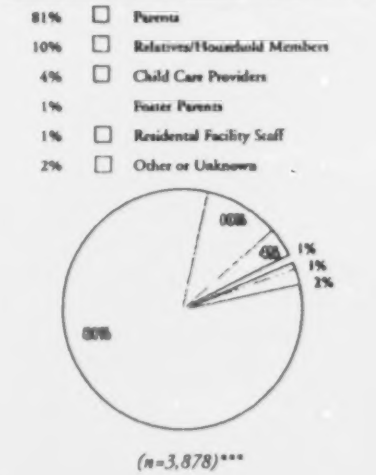
*(n=3,060)**

By Type of Abuse



*(n=3,760)***

By Relationship of Victim to Perpetrator



*(n=3,878)****

Notes on Pie Charts

All data are from the Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2000. Numbers may not add to 100 due to rounding.

**These data reflect an unduplicated count of child victims. The number of victims is higher than the number of indicated cases. One indicated case can involve more than one child victim.*

***This number is greater than the unduplicated count of child victims because children often experience more than one maltreatment event and/or more than one type of abuse. Within each type of abuse, the number of child victims is unduplicated.*

****Perpetrators can abuse more than one child and can abuse a child more than once.*

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Sexual Abuse in Rhode Island, 2000

◇ In Rhode Island in 2000, there were 357 indicated allegations of sexual abuse involving 254 children. Some children were victims of sexual abuse more than once. An indicated allegation of sexual abuse is defined as one in which credible evidence was found indicating sexual abuse.

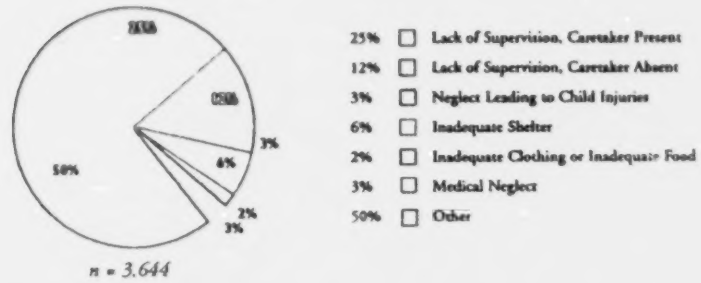
◇ In 76% (270) of the 357 instances of sexual abuse, the victim was female. In 19% of instances the victim of sexual abuse was age 5 or younger, in 39% of instances the victim was between age 6 and 11, and in 42% of instances the victim was age 12 or older.

◇ The most frequent perpetrators of sexual abuse were parents (18%), babysitters/caretakers (18%), relative caretakers (15%), and other household member caretakers (15%). There were 7 (2%) instances of sexual abuse by a foster parent and no instances of sexual abuse by day care providers.

◇ It is widely known that sexual abuse, like other forms of abuse, is frequently underreported.[11] Victims of childhood sexual abuse are more likely to be sexually re-victimized as adults. Studies indicate that more than two-thirds of child victims are also victims of sexual abuse in adulthood.[12]

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2000.

Child Neglect, by Category of Neglect, Rhode Island, 2000



n = 3,644

◇ In 2000 in Rhode Island, there were 3,644 indicated cases of neglect in Rhode Island involving 2,652 children. An indicated case can involve more than one child and each child can be neglected more than once.

◇ The single largest categories of neglect involved lack of supervision by a caretaker – either with the caretaker present but not providing adequate supervision or with the caretaker absent (i.e. leaving children alone without adequate supervision).

◇ Half of all incidents of neglect in 2000 were due to other issues, including abandonment (10); excessive/inappropriate discipline (6); educational neglect (29); failure to thrive (18); tying or close confinement (16); substance abuse of the minor (9); infants born drug-addicted (18); and other, unspecified incidents (1,712).

◇ In Rhode Island in 2000, the three child deaths resulting from abuse or neglect were each categorized as resulting from neglect. Families overwhelmed by multiple personal, social, or economic problems may lack the resources to meet their children's needs and require a variety of readily accessible services and interventions.[13]

Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2000.

Child Abuse and Neglect

DCYF (CANTS)* Hotline Calls for Reports of Abuse and/or Neglect, Investigations, and Indicated Cases, Rhode Island, 1995-2000

YEAR	TOTAL NUMBER UNDUPLICATED CHILD MALTREATMENT REPORTS	NUMBER OF COMPLETED INVESTIGATIONS**	NUMBER OF INDICATED CASES
1995	13,841	8,553	2,781
1996	13,098	8,398	2,541
1997	12,437	8,485	2,577
1998	12,674	8,463	2,459
1999	13,519	7,882	2,628
2000	13,580	7,635	2,234

◇ In 2000, DYCF received 13,580 calls to the Rhode Island Child Abuse Hotline (1-800-RI-CHILD); completed 7,635 investigations of child abuse reports; and determined that there were 2,234 indicated cases in which credible evidence existed that child abuse and/or neglect occurred.

** Child Abuse and Neglect Tracking System*
*** One CANTS investigation can be generated by multiple hotline calls.*

Source: All data are from the Rhode Island Department of Children, Youth and Families, 1995-2000.

Rhode Island Child Deaths Due to Child Abuse and/or Neglect*

YEAR	NUMBER OF DEATHS	YEAR	NUMBER OF DEATHS
1991	7	1996	4
1992	4	1997	2
1993	3	1998	3
1994	5	1999	3
1995	5	2000	3
Total 1991-1995	*24*	*Total 1996-2000*	*15*

◇ Between 1991 and 2000 in Rhode Island, 39 children died as a result of injuries due to abuse by a parent or caretaker.

**Based on R.I. Department of Children Youth and Families determination of death due to child abuse or neglect by a parent or caretaker.*

Community Child Protection: A Collaborative Approach

Child protection systems in many states find their capacity overwhelmed by the increasing rates of reported child abuse and the increasing complexity and severity of family problems, especially substance abuse.[14] In response, some states are experimenting with a community-centered approach to child protection and child abuse/neglect prevention.[15,16] Community child protection initiatives include the following components:

Prevention

A well-coordinated system of supports and services for families is needed in order to prevent maltreatment and its recurrence. The most effective systems also identify maltreatment, have systems to hold perpetrators accountable, and provide treatment for victims of abuse.

Shared Responsibility and Collaboration

Given the magnitude of the child abuse and neglect problem, the child protection agency is unable to address it adequately without community partners. A cooperative network of public and private agencies, service providers, and individuals can lead to shared responsibility and improved services. Cross-training, one-stop service centers, and multidisciplinary teams of professionals help to support effective collaboration.

Individualized Responses

Effective services are coordinated around individualized family needs and draw on family strengths. To the extent safe and possible, family participation in service planning is encouraged and family relationships are preserved even if it is necessary to remove the child from the home, either temporarily or permanently.

Table 20. **Indicated Cases of Child Abuse & Neglect, Rhode Island, 2000**

CITY/TOWN	TOTAL POPULATION OF CHILDREN UNDER AGE 21	NUMBER OF INDICATED CASES OF CHILD ABUSE/NEGLECT	2000 RATE OF CASES OF CHILD ABUSE/NEGLECT PER 1,000 CHILDREN
Barrington	4,487	12	2.7
Bristol	6,186	20	3.2
Burrillville	5,109	38	7.4
Central Falls	5,579	71	12.7
Charlestown	1,783	19	10.7
Coventry	8,880	52	5.9
Cranston	17,558	111	6.3
Cumberland	7,523	39	5.2
East Greenwich	3,346	16	4.8
East Providence	12,520	71	5.7
Exeter	1,710	6	3.5
Foster	1,358	4	2.9
Glocester	2,944	14	4.8
Hopkinton	2,123	15	7.1
Jamestown	1,282	4	3.1
Johnston	6,309	52	8.2
Lincoln	4,543	27	5.9
Little Compton	867	6	6.9
Middletown	5,598	51	9.1
Narragansett	3,757	13	3.5
Newport	7,858	68	8.7
New Shoreham	184	0	0
North Kingstown	6,993	53	7.6
North Providence	6,846	52	7.6
North Smithfield	2,724	19	7.0
Pawtucket	19,655	203	10.3
Portsmouth	4,716	15	3.2
Providence	52,674	672	12.8
Richmond	1,766	6	3.4
Scituate	2,809	9	3.2
Smithfield	5,955	15	2.5
South Kingstown	9,612	29	3.0
Tiverton	3,752	12	3.2
Warren	2,851	28	9.8
Warwick	21,596	154	7.1
Westerly	5,771	52	9.0
West Greenwich	1,067	7	6.6
West Warwick	7,818	115	14.7
Woonsocket	12,511	221	17.7
Out of State/Unknown	*NA*	*59*	*NA*
Core Cities	*98,277*	*1,235*	*12.6*
Remainder of State	*182,343*	*1,136*	*6.2*
Rhode Island	*280,620*	*2,371*	*8.4*

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Child Abuse and Neglect

Source of Data for Table/Methodology

Data are from the State of RI Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), number of reports (indicated cases) for the period January 1, 2000 to December 31, 2000. Population data are from U.S. Bureau of the Census, 1990 Census of Population.

An indicated case is an investigated report of child abuse and neglect for which credible evidence exists that child abuse and/or neglect occurred. An indicated case can involve more than one child.

The denominator is the number of children under the age of 21 according to the 1990 Census of Population.

References for Indicator

[1,2,3] *America's Children at Risk: A National Agenda for Legal Action* (1993). Chicago, IL: American Bar Association, Working Group on the Unmet Legal Needs of Children and Their Families.

[4,5,6] "Protecting Children from Abuse and Neglect" in *The Future of Children*, Vol. 8, No. 1 (Spring, 1998). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[7] *Hidden Casualties: The Relationship between Violence and Learning* (1995). Washington, DC: The National Health and Education Consortium.

[8] *DCYF: Vision and Current Reality* (November, 2000). Providence, RI: Department of Children, Youth and Families.

[9] *A Review of the Rhode Island Department of Children, Youth and Families* (2000). Providence, RI: Rhode Island Public Expenditure Council.

[10] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST) 2000.

[11] Rhode Island Department of Health, Hospital Discharge Database, FY 1999.

[12] Foreman, T. and Bernet, W. (May 2000). "A Misunderstanding Regarding the Duty to Report Suspected Abuse" in *Child Maltreatment*, Vol. 5, No.2, 190-196. Sage Publications, Inc.

[13] Grauerholz, L. (February 2000) "An Ecological Approach to Understanding Sexual Revictimization: Linking Personal, Interpersonal, and Sociocultural Factors and Processes" in *Child Maltreatment*, Vol. 5, No.1, 5-17. Sage Publications, Inc.

[14,15] *We Are In This Together, Community Child Protection* (1998).New York, NY: Edna McConnell Clark Foundation.

[16] "Community Collaborations: A Growing Promise in Child Welfare" in *Best Practice / Next Practice*, Vol. 1, No.2 (Fall 2000). Washington, D.C.: National Child Welfare Resource Center for Family-Centered Practice, A Service of the Children's Bureau, U.S. Department of Health and Human Services.

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Children in Out-of-Home Placement

DEFINITION

Children in out-of-home placement is the number of children in the care of the Rhode Island Department of Children, Youth and Families while awaiting permanent placement. Out-of-home placements include foster homes, placement with a relative or friend, group home, shelter care, residential treatment, and medical facility. Permanent placement includes reunification with the family, adoption, or guardianship.

SIGNIFICANCE

Children need stability, permanency and safety in order to develop and flourish. Removal from the home may be necessary for the child's safety and well-being; however, it is disruptive and can be traumatic for both the child and the family.[1] Children who have been abused or neglected are particularly vulnerable and in need of a safe, stable and permanent environment which provides for their well-being. Yet children in out-of-home care frequently remain in temporary placements for extended periods of time. They are likely to experience multiple placements and lose contact with family members, friends and neighborhoods. They may experience recurrence of abuse.[2] Older children may linger in care until adulthood.

Long-term stays in temporary out-of-home placement can negatively affect children, causing emotional, behavioral or educational problems that adversely affect their future well-being and self-sufficiency.[3]

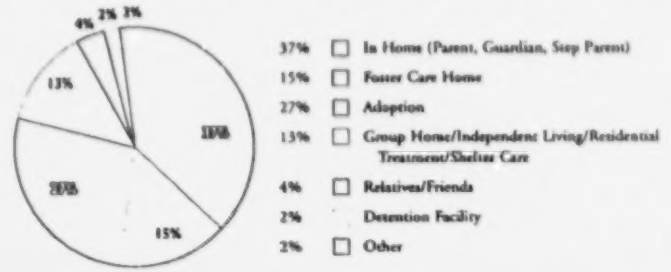
The goal of the the federal Adoption and Safe Families Act of 1997 (ASFA) is to ensure that out-of-home placement is stable, safe, and that it leads to a permanent placement (such as reunification, adoption or guardianship) as quickly as possible without jeopardizing safety. ASFA shortens the time frame for a child's first permanency hearing, offers states financial incentives for increasing the number of adoptions, and sets new requirements for states to petition for termination of parental rights. States are required to track how long children remain in out-of-home placement, how many placements they experience, how frequently they are re-abused, and where they go after leaving state custody.[4,5]

On December 31, 2000 there were 2,451 Rhode Island children in out-of-home care, a rate of 9 children in out-of-home care for every 1,000 children under age 21.[6,7]

DCYF Caseload:

On December 31, 2000 the total active caseload of the Rhode Island Department of Children, Youth and Families was 7,774 children. This number includes 2,061 children who have been adopted and whose families receive subsidies or other financial support to address the child's special needs. This number does not include the children in pending abuse and neglect investigations.

Children in DCYF Care by Living Arrangement, December 2000



◇ As of December 31, 2000, one-third of the DCYF caseload was in out-of-home placements. Out-of-home placements include foster homes (relative, non-relative and specialized), placement with a relative or friend, group home, shelter care, residential treatment, and medical facilities. There were 2,451 Rhode Island children under age 21 in the care of DCYF in out-of-home placements. An additional 115 were classified as "runaways".

◇ Night-to-night placements refer to the temporary nightly placement of youths under the care of DCYF who are awaiting foster home placement or a group home/treatment placement or who have run away from their current placement. Between January and December 2000, there was an average of 230 instances of night-to-night placement per month involving an average of 88 children per month. In 2000, an average of 61 teen girls per month and an average of 27 teen boys per month were in night-to-night placements.[8]

Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2000.

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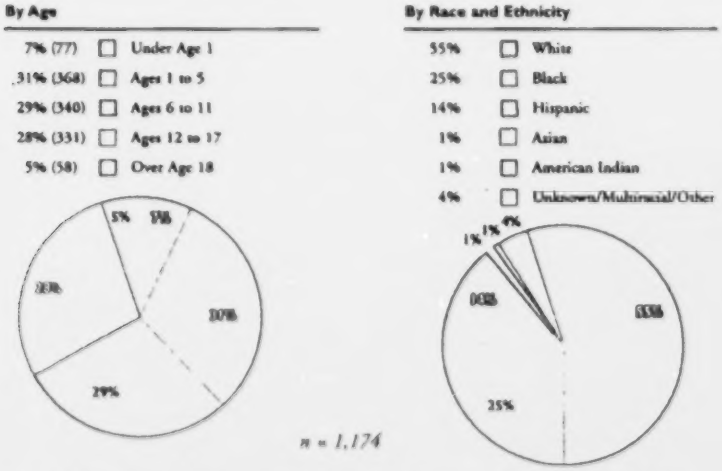
Children in Foster Care Homes, Rhode Island, 2000

As of December 2000, there were 1,174 children in foster care homes. Of these, 557 (47%) were in non-relative foster homes, 502 (43%) were in relative foster homes, and 115 (10%) were in the care of private agencies. There were 554 licensed foster care homes, 419 relative foster care homes, and 185 licenses pending. In addition, there were 202 licensed private agency foster homes and 85 pending licenses for private agency foster homes.[9]



Source: Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), December 2000.

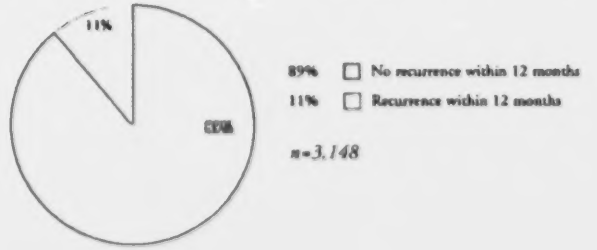
◇ Child abuse and neglect happens to children of all races and economic classes. But national data indicate that poor families and families of color are more likely to be identified by the child welfare system and are more likely to have their children removed and placed in foster care. Once in foster care, children of color are more likely to remain there for long periods of time, and to experience multiple placements.[10]

Child safety, permanency and well-being are recognized as the broad goals of child protection systems under the Adoption and Safe Families Act.

ENSURING THE SAFETY OF CHILDREN IN OUT-OF-HOME PLACEMENT

The safety of all children who come to the attention of a child protection agency is a priority in any decision regarding removal from the home, placement, and permanency planning. Protecting children from abuse or neglect while in state custody is also a paramount concern.

Recurrence of Maltreatment, Rhode Island, 1997-1998



◇ Of the 3,148 Rhode Island children who were victims of abuse or neglect in 1997 (whether or not they were removed from the home), 11% (346) experienced one or more recurrences of abuse or neglect within 12 months.

◇ Rhode Island data regarding abuse or maltreatment of children in out-of-home-placement is not yet available as a separate measure but will be reported in 2001.

Source: *Child Welfare Outcomes 1998: Annual Report* (April 2000) U.S. Department of Health and Human Services, Detailed Case Data Component (DCDC) of the National Child Abuse and Neglect Data System (NCANDS).

PERMANENCY FOR CHILDREN IN OUT-OF-HOME PLACEMENT

A child welfare system's effectiveness in achieving permanency for children in out-of-home placement includes three interrelated measures: the timeliness and lasting effect of a permanent placement; the stability of temporary placements; and the number of successful permanent placements.[11]

Length of Time to Reunification or Adoption, Rhode Island, FY1998*

	Reunification	Adoption
Less than 12 months	66%	5%
12-23 months	9%	23%
24-35 months	2%	14%
36-47 months	2%	21%
48 months or more	2%	29%
Missing	19%	9%
Total Number	*542*	*117*

◇ The data currently collected by states for federal reporting purposes focuses on duration in placement for children exiting care to reunification with their family or adoption. For children who do not exit out-of-home placement in a given year the length of time in temporary placements is also a concern.

◇ To ensure that pressure to speed up reunification is not affecting recurrence of maltreatment or other breakdowns in placement, success in reducing the duration in temporary placement must be measured in conjunction with rates of re-entry into the system. In FY 1998, one-quarter (26%) of the children in Rhode Island who entered out-of-home placement were re-entering after a prior episode.

◇ Because of federal requirements and guidelines governing the collection of data about children in out-of-home placement, fiscal year (FY) throughout this indicator refers to the federal fiscal year (October 1- September 30).

Source: *Child Welfare Outcomes 1998, Annual Report* (April 2000) U.S. Department of Health and Human Services, Detailed Case Data Component (DCDC) of the National Child Abuse and Neglect Data System (NCANDS).
Note: Data on re-entry were missing for 25% of cases

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Placement Stability for Children in Out-of-Home Placement

◇ In FY 1998, 27% of children who had been in out-of-home care for less than one year had experienced 3 or more placements. Three or more placements were experienced by 47% of children who had been in care between 12 and 23 months, and 54% of children who had been in care for 24-35 months.[12]

Number of Permanent Placements Achieved in Rhode Island, FY 1998

Children Who Exited Foster Care in FY1998

	All Exits	With Disability	Age 12 or more at entry
Adoption	13%	12%	0%
Guardianship	2%	0%	1%
Reunification	59%	51%	56%
Other	12%	14%	19%
Missing	14%	23%	23%
Total Number	*915*	*160*	*388*

◇ Children exiting care are only a fraction of those in care. In FY1998, DCYF served 3,530 children in out-of home placements; of these, 915 exited care, and 74% (or 677) exited to a permanent placement such as adoption, guardianship or reunification.

◇ Those who do not exit care may eventually "age out" when they turn 18, never having found a permanent placement. In FY1998, 36 children aged-out of foster care. Of these, 81% were older than age 12 at entry into foster care.

◇ In Rhode Island, teens represent one-quarter of the children in foster care. In 1999, Congress passed the John H. Chafee Foster Care Independence Act that provides federal funding for foster care teens after they turn 18. The resources are meant to help teens leaving the foster care system make a successful transition to self-sufficiency as adults.[13]

Source: *Child Welfare Outcomes 1998, Annual Report* (April 2000). U.S. Department of Health and Human Services, AFCARS Annual Foster Care Database.

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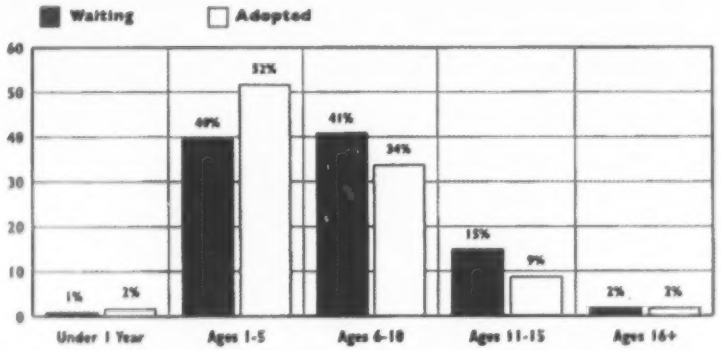
WELL-BEING FOR CHILDREN IN OUT-OF-HOME PLACEMENT

While specific indicators for measuring safety and permanency have been developed and implemented, the U.S. Department of Health and Human Services is still in the process of defining similar indicators of well-being. It is expected that, at a minimum, these will include the receipt of appropriate health, mental health, and education services by children in out-of-home placement.[14]

◇ Both temporary and permanent placement may require a variety of supports and services for the child and the family. Current estimates indicate that between 50% and 80% of families involved with child protective services are dealing with a substance abuse problem, and thus may require specialized treatment for both adults and children.[15,16]

◇ An increasing number of children entering relative and non-relative foster care homes have significant emotional, behavioral and medical needs, including developmental delays, low birth weight, congenital diseases, and health problems due to prenatal drug exposure.[17] The complex needs of these children require adequate support and training for foster and adoptive parents and a comprehensive array of services and supports in the community.[18]

Children Waiting to Be Adopted (as of 9/30/98) and Children Adopted in FY 1998, Rhode Island



Source: *Child Welfare Outcomes 1998, Annual Report* (April 2000) U.S. Department of Health and Human Services, AFCARS Annual Foster Care Database. Number of waiting children was 322 and number of adopted children was 222.

◇ In 2000 in Rhode Island 242 petitions for termination of parental rights (TPR) were filed and 104 were decided. With increasing emphasis on expediting TPRs in order to facilitate adoptions, there is renewed concern over whether children who are "freed" for adoption, particularly older children or children with disabilities, in fact have any hope of adoption or other permanent placement.[19]

◇ Maintaining a sufficient number of foster homes is a continuing concern, particularly if increased adoption rates by foster parents result in reductions in the number of families willing to provide foster homes. In 2000 in Rhode Island, 85 foster families adopted a child.[7]

◇ In December 2000, there were 109 Rhode Island children waiting to be adopted who did not have a prospective adoptive family identified. Approximately 40% of these children have experienced an adoptive placement disruption.[20]

References

[1] "Protecting Children from Abuse and Neglect" (Spring 1998) in *The Future of Children*, Vol. 8, No.1 (Spring, 1998). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[2,3,11,12,14] *Child Welfare Outcomes 1998, Annual Report* (April 2000). Washington, DC: U.S. Department of Health and Human Services.

[4] Lovejoy, Anna (October 2000). *A Place to Call Home: State Efforts to Increase Adoptions and Improve Foster Care Placements*. National Governor's Association Center for Best Practices.

[5] *Foster Care: States' Early Experiences Implementing the Adoption and Safe Families Act* (December 1999). Washington, DC: U.S. General Accounting Office.

[6,9] Rhode Island Department of Children, Youth and Families, Rhode Island Children's Information System (RICHIST), 2000.

[7] U.S. Bureau of the Census, 1990 Census of Population.

[8] Rhode Island Office of the Child Advocate, 2000.

[10,17] *America's Children at Risk: A National Agenda for Legal Action* (1995). Chicago, IL: American Bar Association, Working Group on the Unmet Legal Needs of Children and Their Families.

[13] *Frequently Asked Questions about the Foster Care Independence Act of 1999 and the John H. Chafee Foster Care Independence Program* (February, 2000). Seattle, WA: Children's Defense Fund, Child Welfare League of America, and National Association of Child Advocates.

[15] English, D (Spring 1998). "The Extent and Consequences of Child Maltreatment" in *The Future of Children*, Vol. 8, No.1. Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[16] *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection* (April 1999). Washington, DC: U.S. Department of Human Services.

[18] *Family to Family: Tools for Rebuilding Foster Care* (1999). Baltimore, MD: The Annie E. Casey Foundation.

[19] State of Rhode Island Family Court Juvenile Clerk's Office, 2000.

[20] Adoption Rhode Island, 2000.

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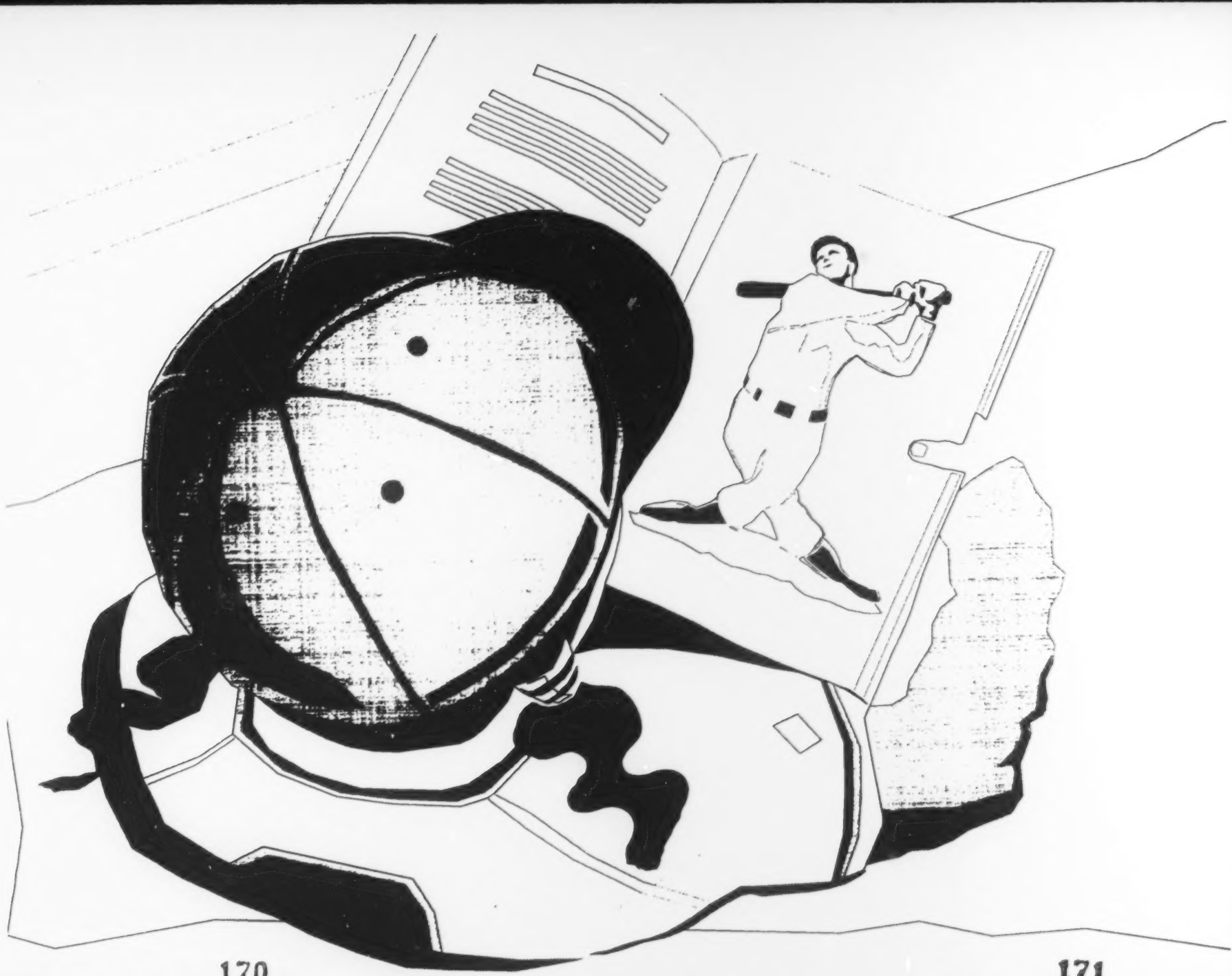
Education

Dreams

By Langston Hughes

Hold fast to dreams
for if dreams die
Life is a broken-winged bird
That cannot fly.

Hold fast to dreams
For when dreams go
Life is a barren field
Frozen with snow.



Infant and Pre-School Child Care

DEFINITION

Infant and pre-school child care is the number of regulated child care slots per 100 children under age 6 in need of regulated child care. Regulated child care slots include full-time licensed child care center slots and certified family child care home slots.

SIGNIFICANCE

Child care has become a fundamental need for Rhode Island families over the past two decades. Well-designed child care programs can promote healthy cognitive, emotional and social development.[1] High quality child care provides a safe and nurturing learning environment for infants and young children. Recent brain research indicates that early care and education has long-lasting effects on how children learn and develop, cope with stress, and handle their emotions.[2]

In quality child care programs, children receive the attention they need in small groups with low staff-to-child ratios, children learn from qualified teachers who are adequately compensated, and parents are involved in their child's early care experience.[3] Children from all backgrounds who have received high quality child care score higher on tests of both cognitive and social skills in their early school years than children in poor quality care.[4,5] Low-income children who receive high quality early education score significantly higher on tests of reading and math from primary grades through middle adolescence.[6]

The quality and stability of child care is critical to a parent's ability to work.[7] In Rhode Island in 1998, 69% of mothers with children under the age of six were in the labor force.[8] More than 45,000 Rhode Island infants and pre-school children are in need of some form of child care because the mother is in the labor force.[9] Nationally, 50% of infants under age one, 68% of three-year-olds, and 78% of four-year-olds participate in some form of child care on a regular basis.[10,11]

In 2000 in Rhode Island, there were 21,482 regulated child care slots for children under age six in need of a licensed child care center or certified family child care home, as compared with 15,483 regulated child care slots in 1995. In 2000 in Rhode Island, 28 of the 253 licensed child care centers were accredited by the National Association for the Education of Young Children and 11 of the 973 certified family child care homes were accredited by the National Association for Family Child Care.[12]

Welfare to Work and Access to Child Care

◆ Changes in welfare laws linking cash assistance to work or participation in work-readiness programs mean additional children are in need of quality child care. Studies demonstrate that participation in high-quality early childhood development programs is linked to improved school readiness among children from low-income families.[13]

◆ One factor that influences the choice of child care among families leaving welfare is their need for child care during non-standard work hours (weekends, nights, rotating shifts) and the lack of adequate center-based opportunities for such care. As a result, low-income families must often rely on informal, unstable and multiple child care arrangements. Many rely on relatives and friends.[14,15,16]

◆ Expanding the supply of formal, high-quality child care during nonstandard-hours through dedicated resources and incentives is one approach to this problem. Another is raising the quality of care offered by family child care homes and by kith and kin. Providing resources, supports, and professional development opportunities for such caregivers, including caregivers who may not be interested in opening a child care business, can improve quality.[17]

The Child Care Workforce

◆ A staff with more formal education and specialized early childhood training provides better quality services for children and families. Professional training is most effective when providers learn about child and family development, management, and child care policies; gain credentials that are linked to compensation or transfer to other career pathways; and form networks of support, engage in continuous learning from their peers and become mentors to others.[18]

◆ One of the most important predictors of the quality of child care are staff wages. Workers in the child care field are underpaid, resulting in high staff turnover. This contributes to the disruption in continuity of care for many young children.[19] In Rhode Island in 1998, the median hourly wage for child care workers was $7.19 compared to $12.01 for all workers in the labor force.[20]

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Table 21.

Child Care for Children Under Age 6, Rhode Island, 2000

CITY/TOWN	# CHILD CARE CENTER SLOTS < AGE 3	# CHILD CARE CENTER SLOTS AGES 3-5	# CERTIFIED FAMILY CHILD CARE HOME SLOTS*	TOTAL REGULATED CHILD CARE SLOTS FOR CHILDREN < AGE 6	POTENTIAL CHILDREN < AGE 6 IN NEED OF REGULATED CHILD CARE	SLOTS PER 100 CHILDREN < 6 IN NEED OF REGULATED CHILD CARE
Barrington	96	211	52	359	314	114
Bristol	53	104	86	243	590	41
Burrillville	16	78	63	157	471	33
Central Falls	39	137	142	318	690	46
Charlestown	16	12	28	56	164	34
Coventry	81	193	196	470	764	62
Cranston	313	852	367	1,532	1,498	102
Cumberland	51	85	195	331	654	51
East Greenwich	194	331	30	555	179	310
East Providence	244	653	174	1,071	1,256	85
Exeter	14	31	19	64	163	39
Foster	30	36	5	71	107	66
Glocester	16	66	43	125	264	47
Hopkinton	0	0	33	33	182	18
Jamestown	31	33	28	92	97	95
Johnston	105	350	143	598	510	117
Lincoln	176	425	68	669	414	162
Little Compton	0	0	0	0	86	0
Middletown	148	320	30	498	469	106
Narragansett	41	90	29	160	321	50
Newport	126	210	48	384	653	59
New Shoreham	0	0	0	0	24	0
North Kingstown	123	333	112	568	596	95
North Providence	67	193	150	410	592	69
North Smithfield	0	0	65	65	185	35
Pawtucket	270	638	421	1,329	2,400	55
Portsmouth	82	126	44	252	393	64
Providence	791	2,319	2,323	5,433	5,387	101
Richmond	0	37	46	83	173	48
Scituate	47	92	10	149	258	58
Smithfield	143	265	56	464	368	126
South Kingstown	130	297	92	519	479	108
Tiverton	25	145	51	221	296	75
Warren	25	152	53	230	326	71
Warwick	446	1,145	324	1915	1,691	113
Westerly	72	387	24	483	556	87
West Greenwich	91	87	6	184	92	200
West Warwick	134	382	115	631	694	91
Woonsocket	105	457	198	760	1,341	57
Core Cities	*1,331*	*3,761*	*3,132*	*8,224*	*10,472*	*79*
Remainder of State	*3,010*	*7,511*	*2,737*	*13,258*	*15,230*	*87*
Rhode Island	*4,341*	*11,272*	*5,869*	*21,482*	*25,701*	*84*

**Family child care home slots are for children birth to 12-years-old.*

Source of Data for Table/Methodology

The denominator is the potential number of children in need of regulated care. See methodology on page 110. The number of regulated child care slots is the number of licensed full-time child care center slots for children under age 6 and the number of certified family child care home slots as of December 2000. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

References

1,2,3,5 *Early Childhood Care and Education: An Investment That Works* (1999). Washington, DC: National Conference of State Legislatures.

4 Shore, R. (1997). *Rethinking the Brain.* New York: Families and Work Institute.

6 Schulman, K., Blank, H. & Ewen, D. (1999). *Seeds to Success: State Prekindergarten Initiatives, 1998-1999.* Washington, DC: Children's Defense Fund.

7,10 *The Children of the Cost, Quality, and Outcomes Study Go to School* (June 1999). Chapel Hill, NC: The University of North Carolina at Chapel Hill.

8 Vandell, D. Lowe and Wolfe, B. (2000). *Child Care Quality: Does It Matter and Does It need to be Improved?* Madison, WI: Institute for Research on Poverty, University of Wisconsin.

9 *Early Learning, Later Success: The Abecedarian Study, Executive Summary* (1999). Chapel Hill, NC: Frank Porter Graham Child Development Center, University of North Carolina.

11 U.S. Bureau of the Census, Current Population Survey, 1996-2000.

12 U. S. Bureau of the Census, 1990 Census of Population.

13 Booth, C. (1999). *Consequences of Early Child Care: Studying the Contexts of Early Experiences in the 1990's.* NICHD Early Child Care Research Network.

14 Options for Working Parents (December 2000).

15 Zaslow, M., Oldham, E., Moore K. and Magenheim, E. (1998). "Welfare Families' Use of Early Childhood Care and Education Programs, and Implications for Their Children's Development" in *Early Childhood Research Quarterly*, Vol 13 No. 4, 535-563.

16 Schumacher, R. and Greenberg, M (October 1999). *Child Care after Leaving Welfare: Early Evidence from State Studies.* Washington, DC: Center for Law and Social Policy.

17 Shelton, E., Roy, C., and Ulstad, K. (March 1999). Parents' Views on Child Care and Child Care Assistance in the First Year of Statewide Welfare Reform: A Report to Children's Home Society of Minnesota. Saint Paul, MN: Wilder Research Center.

18 *Care Around the Clock: Developing Child Care Resources Before Nine and After Five, Executive Summary* (1995). Washington, DC: Women's Bureau, U.S. Department of Labor.

19 Collins, A and Carlson, B. (1998). "Child Care by Kith and Kin--Supporting Family, Friends and Neighbors Caring for Children" in *Children and Welfare Reform, Issue Brief 3.* New York, NY: National Center for Children in Poverty.

20 *2000 Kids Count Data Book: State Profiles of Child Well-Being* (2000). Baltimore, MD: The Annie E. Casey Foundation.

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Children Enrolled in Head Start

DEFINITION

Children enrolled in Head Start is the percentage of eligible 3 and 4 year old children enrolled in the Head Start preschool program as of October 1, 2000.

SIGNIFICANCE

Head Start is a comprehensive early childhood program for low-income preschool children and their families. The program seeks to promote the healthy development of children in low-income families and help their parents achieve self-sufficiency. Most children in the program attend for one year and are four years old.[1] Children are eligible for Head Start if their family's income is below 100% of the federal poverty line; the family receives SSI or is enrolled in the Family Independence Program; or the family is using supportive services that are federal TANF benefits, such as transportation vouchers, subsidized child care, or job training. Up to 10% of the children served by Head Start can be in families that do not meet these eligibility guidelines, especially if the child has a special need.

The Head Start program is designed to provide low-income children with the socialization and school-readiness skills they need to enter public schools on an equal footing with more economically advantaged children.[2] Head Start performance standards require that programs deliver a high-quality early childhood education program; involve parents in program policy and planning; provide at least one nutritional meal per day; identify children's individual nutritional needs; ensure that each child has an ongoing source of health care; perform or obtain health, developmental and behavioral screenings; and make arrangements for mental health professionals to be available to identify mental health concerns and help locate needed treatment.[3]

Studies show that children in poor families are at greater risk for developmental delays, learning disabilities, and behavior problems; have a greater prevalence of health and nutrition problems; and are more likely to live in substandard housing and be exposed to violence and substance abuse.[4]

Disadvantaged children are most sensitive to the effects of poor quality child care and benefit most from high quality comprehensive child care programs.[5] Comprehensive programs that focus both on child development and family development are most effective in supporting vulnerable families and children.[6] Children who receive a high quality early education program combined with health, social and nutritional services outperform their peers on both cognitive and academic tests and are more likely to attend college and hold high-skilled jobs.[7]

Head Start and Comprehensive Child Care Programs

◇ Low-income children benefit most from high-quality comprehensive child care programs. Comprehensive programs that focus both on child development and family development are most effective in supporting positive outcomes for vulnerable families and children.[8]

◇ Recognizing that Head Start is available to fewer than half of Rhode Island's lowest income children, resources were appropriated under Starting Right (Rhode Island's 1998 child care law) to create comprehensive child care networks in underserved communities.

◇ Comprehensive Child Care Networks are modeled on Head Start and will provide a developmentally-appropriate education program; transition assistance among child care programs and schools; health services; mental health services; support for children with disabilities; nutrition services; family education and empowerment; and services that expand community linkages and partnerships.

◇ Comprehensive Child Care Networks must be certified by the Rhode Island Department of Human Services. The Certification and Performance Standards that were published in January 2000 are based on Head Start Performance Standards.

◇ Four Comprehensive Child Care Networks have received funding to develop and provide comprehensive child care services in Providence, Pawtucket, Cranston, East Providence, Bristol, Warren, Warwick, and North Kingstown. These networks include a total of two Head Start programs, 16 child care centers, and 21 family child care providers.

◇ The Department of Human Services expects that comprehensive child care services will begin to be provided in 2001. By January of 2002, up to 450 previously unserved or underserved three and four-year-old children will be served by Comprehensive Child Care Networks.

◇ To be eligible for Comprehensive Child Care Services, families must have annual incomes not exceeding $15,282 for a family of three. Children in the lowest-income families are targeted for services to ensure that the most disadvantaged children receive the services they need to start school ready to learn.[9,10]

Table 22 **Percent of Eligible Children Ages 3 and 4 Enrolled in Head Start, Rhode Island, 2000**

CITY/TOWN	ESTIMATED ELIGIBLE CHILDREN AGED 3&4	NUMBER OF CHILDREN ENROLLED IN HEAD START	% OF ELIGIBLE 3&4 YEAR OLDS ENROLLED
Barrington	5	3	60%
Bristol	35	18	51%
Burrillville	26	17	65%
Central Falls	283	52	18%
Charlestown	12	4	33%
Coventry	63	47	75%
Cranston	206	211	100%
Cumberland	40	7	18%
East Greenwich	13	7	54%
East Providence	160	109	68%
Exeter	7	0	0%
Foster	3	3	100%
Glocester	9	7	78%
Hopkinton	18	12	67%
Jamestown	3	0	0%
Johnston	72	46	64%
Lincoln	30	7	23%
Little Compton	1	2	100%
Middletown	26	43	100%
Narragansett	27	11	41%
Newport	194	139	72%
New Shoreham	2	0	0%
North Kingstown	56	30	54%
North Providence	92	53	58%
North Smithfield	6	2	33%
Pawtucket	589	122	21%
Portsmouth	11	12	100%
Providence	2,386	917	38%
Richmond	9	2	22%
Scituate	11	3	27%
Smithfield	11	8	73%
South Kingstown	28	30	100%
Tiverton	17	33	100%
Warren	32	17	53%
Warwick	203	141	69%
Westerly	62	57	92%
West Greenwich	3	0	0%
West Warwick	145	131	90%
Woonsocket	395	220	56%
Core Cities	*3,847*	*1,450*	*38%*
Remainder of State	*1,444*	*1,073*	*74%*
Rhode Island	*5,291*	*2,523*	*48%*

Source of Data for Table/Methodology

Rhode Island Head Start Programs, children enrolled on October 1, 2000; U.S. Department of Health and Human Services, Region 1, Administration on Children, Youth and Families; and Rhode Island Department of Human Services INRHODES Database, December 1, 1996-1998.

The denominator is the estimated number of eligible children based on a three-average of the number of three- and four-year-old children in families receiving FIP at a single point in time during each of three years: 1996, 1997, and 1998. This is an underestimate of children eligible, because it does not include children eligible for Head Start who live in non-AFDC/non-FIP families living below the poverty line. Therefore, the actual percentage of eligible served is likely to be lower than shown here.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

References for Indicator

[1] *The Future of Children: Long-Term Outcomes of Early Childhood Programs* (1995). "Head Start". (Vol.5, No. 3). Los Altos, CA: Center for the Future of Children, The David and Lucile Packard Foundation.

[2] *The State of America's Children Yearbook: 1995* (1995). Washington, DC: Children's Defense Fund.

[3] Schulman, K., Blank, H., and Ewen, D. (1999). *Seeds to Success: State Prekindergarten Initiatives, 1998-1999*. Washington, DC: Children's Defense Fund.

[4] Adams, G. and Poersch, N.O. (1996). *Who Cares? State Commitment to Child Care and Early Education*. Washington, DC: The Children's Defense Fund.

[5] *The Children of the Cost, Quality, and Outcomes Study Go to School* (June 1999). Chapel Hill, NC: The University of North Carolina at Chapel Hill.

[6] *The Statement of the Advisory Committee on Services for Families with Infants and Toddlers* (1994). Washington, DC: Department of Health and Human Services.

[7] *Early Learning, Later Success: The Abecedarian Study, Executive Summary* (1999). Chapel Hill: NC: Frank Porter Graham Child Development Center, University of North Carolina at Chapel Hill.

[8] *Starting Right: Quality Early Education and Child Care for Rhode Island's Children and Youth* (July 2000). Cranston, RI: Rhode Island Department of Human Services.

[9] *Certification Standards for Comprehensive Child Care Services Networks* (December 1999). Providence, RI: Rhode Island Department of Human Services, Center for Children and Families, Office of Child Care.

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School-Age Child Care

DEFINITION

School-age child care is the number of licensed child care programs and slots for children ages 5 to 12. These numbers do not include certified family child care home slots, informal child care arrangements, and community programs for youth ages 5 to 12 that do not require licensing by the state.

SIGNIFICANCE

Many parents need care for their school-age children during work hours. Children spend only 20% of their waking hours in school. The gap between parents' work schedules and students' school schedules can amount to 20 or more hours per week.[1] Many children are alone during the hours before and after school. It is estimated that nationally 8 million children ages 5 to 14 spend time without adult supervision on a regular basis.[2] As children get older they are much more likely to care for themselves when not in school. Nationally, while 10% of 6 to 9 year-olds regularly spend time in self-care when not in school, 35% of 10 and 11 year-olds, and 44% of 12 year-olds regularly care for themselves afterschool.[3]

Children who are without adult supervision when school is out are at significantly greater risk of truancy, emotional stress, receiving poor grades, substance use, sexual activity, and crime.[4,5] Juvenile crime peaks between the hours of 3 p.m. and 8 p.m.[6] Children ages 6 to 17 are also more likely to be the victims of violent crime between 2 p.m. and 6 p.m.[7]

Low-income children and children in urban or high-crime neighborhoods are most at risk when they spend time caring for themselves and are most likely to benefit from high quality after-school programming.[8]

When school is out, children and young adolescents need a safe place that does not simply duplicate the school day. They need access to a wide variety of enriching activities – homework and reading help, sports, music, theater, art – and the opportunity to build meaningful relationships with their peers and caring adults.[9] Children in high quality, well-designed after-school programs have better peer relations, emotional adjustment, grades, and conduct in school than their peers in other care arrangements.[10] Yet, many programs are of poor quality due to a lack of resources, staff turnover, and inappropriate space.[11,12]

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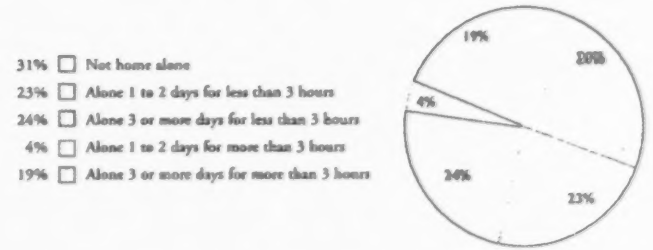
Rhode Island Middle School Children, At Home After School without Adult Supervision, 2000


31% Not home alone
23% Alone 1 to 2 days for less than 3 hours
24% Alone 3 or more days for less than 3 hours
4% Alone 1 to 2 days for more than 3 hours
19% Alone 3 or more days for more than 3 hours
19%
23%
4%
24%

Source: Robert D. Felner, PhD (2000). *SALT Survey Reports, School Year 1999-2000.* Providence, RI: University of Rhode Island, National Center on Public Education and Social Policy. Includes public school children in grades 6, 7, and 8.

Availability of After-School Programs in Rhode Island

◇ In Rhode Island, the supply of licensed school-age programs for children ages 5 to 12 increased from 5,570 slots in 1995 to 12,225 slots in 2000. There continues to be a low supply of before-school and after-school care relative to need.[13]

◇ Children from low-income families are less likely to participate in extracurricular activities than are children from higher income families. In Rhode Island in 2000, 63% of low-income middle school students belonged to and regularly attended at least one extracurricular activity, as compared to 81% of high-income middle school children.[14]

◇ Under Starting Right, Rhode Island's child care law, child care subsidies are an entitlement for all families with incomes less than 225% of poverty. Subsidies can be used for after-school programs for children up to age 16. As of December 2000, there were 4,966 children ages 6 to 16 who were using child care subsidies, 41% of all child care subsidies.[15]

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Table 23.

Licensed School-Age Child Care for Children Ages 5 to 12, Rhode Island, 2000

CITY/TOWN	COMMUNITY-BASED		SCHOOL-BASED		TOTAL	
	PROGRAMS	SLOTS	PROGRAMS	SLOTS	PROGRAMS	SLOTS
Barrington	5	206	1	30	6	236
Bristol	3	52	1	50	4	102
Burrillville	2	143	1	30	3	173
Central Falls	1	49	2	132	3	181
Charlestown	1	18	0	0	1	18
Coventry	3	84	7	326	10	410
Cranston	10	295	6	219	16	514
Cumberland	0	0	5	225	5	225
East Greenwich	1	40	2	130	3	170
East Providence	4	170	9	527	13	697
Exeter	1	26	1	72	2	98
Foster	2	61	0	0	2	61
Glocester	0	0	2	118	2	118
Hopkinton	0	0	0	0	0	0
Jamestown	0	0	1	50	1	50
Johnston	3	65	4	164	7	229
Lincoln	3	125	1	40	4	165
Little Compton	1	26	0	0	1	26
Middletown	3	58	4	196	7	254
Narragansett	0	0	1	60	1	60
Newport	2	346	7	25	9	371
New Shoreham	0	0	0	0	0	0
North Kingstown	5	131	2	90	7	221
North Providence	1	100	1	50	2	150
North Smithfield	0	0	1	100	1	100
Pawtucket	5	597	5	323	10	920
Portsmouth	1	32	1	35	2	67
Providence	22	1,430	33	2,077	55	3,507
Richmond	0	0	1	50	1	50
Scituate	2	37	0	0	2	37
Smithfield	2	48	2	200	4	248
South Kingstown	1	18	6	292	7	310
Tiverton	2	95	0	0	2	95
Warren	1	85	2	100	3	185
Warwick	14	693	8	356	22	1,049
Westerly	4	133	4	180	8	313
West Greenwich	1	36	0	0	1	36
West Warwick	2	100	7	376	9	476
Woonsocket	3	189	2	114	5	303
Core Cities	*33*	*2,611*	*49*	*2,671*	*82*	*5,282*
Remainder of State	*78*	*2,877*	*81*	*4,066*	*159*	*6,943*
Rhode Island	*111*	*5,488*	*130*	*6,737*	*241*	*12,225*

Source of Data for Table/Methodology

All data are from Options for Working Parents, Greater Providence Chamber of Commerce, December 2000.

Number of licensed school-age child care programs and slots for children ages 5 to 12 as of December 2000. School-based programs are school-age programs located in schools and may be administered through the school district or a community organization (for example, YWCA, YMCA, etc.). Community-based programs are school-age child care programs located in the community, including child care centers, YMCAs, YWCAs, Boys and Girls Clubs, and other community organizations. These numbers do not include certified family child care home slots, informal child care arrangements, and community programs for youth ages 5 to 12 that do not require licensing by the state.

References for Indicator

[a][b][c] *Fact Sheet on School-Age Children's Out-of-School Time* (January 2000). Wellesley, MA: National Institute on Out-of-School Time, Center for Research on Women, Wellesley College.

[d] *Child Care Patterns of School-Age Children with Employed Mothers* (September 2000). Washington, DC: The Urban Institute, Assessing the New Federalism.

[e] *A Matter of Time: Risk and Opportunity in the Non-school Hours* (1994). New York: Carnegie Corporation, Carnegie Council on Adolescent Development.

[f] Fox, J., and Newman, S. (1997). *After-School Crime or After-School Programs: A Report to the Attorney General.* Washington, DC: Fight Crime, Invest in Kids.

[g] Vandell, D.L. and Shumow, L. "After-School Child Care Programs" in *When School is Out* (Fall 1999). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[h][m] Seligson, M. (1997). *School-Age Child Care Centers of Age.* Wellesley, MA: National Institute on Out-of-School Time, Center for Research on Women, Wellesley College.

[i] Halpern, R. "After-School Programs for Low-Income Children: Promise and Challenges" in *When School is Out* (Fall 1999). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[j] *Working for Children and Families: Safe and Smart After-School Programs* (April 2000) Washington, DC: U.S. Department of Education, Partnership for Family Involvement in Education.

[k] Options for Working Parents, Greater Providence Chamber of Commerce, 1995-2000.

[l] Fehrer, R.D., PhD (2000). *SALT Survey Reports, School Year 1999-2000.* Providence, RI: University of Rhode Island, National Center on Public Education and Social Policy.

[n] Rhode Island Department of Human Services, INRHODES Database, December 2000.

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Children Receiving Child Care Subsidies

DEFINITION

Children receiving child care subsidies is the number of children receiving child care that is either fully or partially paid for with a child care subsidy from the Rhode Island Department of Human Services. Child care subsidies are available to families with income at or below 225% of the federal poverty level ($38,362 for a family of four). Child care subsidies can be used for care by a child care center, family child care home, a relative, or an in-home caregiver.

SIGNIFICANCE

Child care subsidies are an important part of government efforts to increase economic well-being and to promote the healthy development of children from low-income families. National studies have shown that, among mothers of all income levels, higher-cost child care is associated with a higher probability of refusing or terminating employment.[1,2] This is especially true among low-income populations for whom child care costs represent a significant part of families' budgets.[3]

In 1997, poor families who paid for child care spent 23% percent of their earnings, low-income families spent 16% of their earnings.[4] Families with younger children spent a higher share of income on child care than families with older children.[5] Low-skilled single mothers pay the highest proportion of their income on child care.[6]

For many low-income and moderate-income families, the cost of child care can limit access to high-quality programs. The quality and stability of child care is critical to a parent's ability to work and to child development.[7,8] Parents of children in quality child care programs are more likely to be productive workers because they are less hampered by child care problems that result in frequent employee turnover and absenteeism.[9]

Rhode Island is the only state that has a legal entitlement to a child care subsidy for income-eligible families. Working families with incomes up to 225% of the federal poverty line are entitled to a child care subsidy for their children up to age 16. Families receiving subsidies may have a co-payment based on family income. Families participating in the Rhode Island Family Independence Program are eligible for child care at no cost to the family as long as they are working or enrolled in education, training, or work-related activities.[10]

Child Care Subsidies, Rhode Island, December 2000

By Family Income

31%	☐	Cash Assistance (FIP)
64%	☐	Low-Income Working Families
5%	☐	DCYF

By Provider Type

5%	☐	In-Home
65%	☐	Licensed Centers
20%	☐	Family Child Care Homes
10%	☐	Relative

Total Number of Subsidies is 11,900 as of December 2000.

Source: Rhode Island Department of Human Services, December 2000.

◇ In December 2000, almost two-thirds of all child care subsidies in Rhode Island were being used by low-income working families.[11] The cost of child care is often the largest expense, after housing, for working families who need full-time care for their children.[12]

◇ More than four out of five (85%) Rhode Island families receiving child care subsidies choose licensed child care centers or certified family child care homes for their child care arrangements.[13]

◇ As of December 2000, 25% of child care subsidies were for infants and toddlers up to age 3, 35% were for preschoolers ages 3 to 5, and 40% were for school-age children ages 6 to 16.[14]

◇ Even as more child care subsidies become available, there is a structural shortage of child care centers and certified family child care homes necessary to meet demand.[15] The supply of licensed and certified child care is especially limited in low-income communities and rural areas, for infants and children under age 3, for children with disabilities and special health care needs, for middle school-age children, and for parents with unconventional or shifting work hours.[16]

Table 24.

Child Care Subsidies, Rhode Island, 2000

	COMMUNITY CONTEXT		NUMBER OF CHILD CARE SUBSIDIES			
CITY/TOWN	# OF CHILDREN UNDER AGE 16 IN WORKING FAMILIES < 185% POVERTY	# OF CHILDREN UNDER AGE 16 ENROLLED IN FIP*	BIRTH TO AGE 3	AGES 3-5	AGES 6-16	TOTAL CHILD CARE SUBSIDIES
Barrington	49	51	16	29	38	83
Bristol	809	185	18	37	24	79
Burrillville	518	113	5	33	34	72
Central Falls	2935	1,669	74	51	52	17
Charlestown	152	51	7	8	3	18
Coventry	748	252	40	57	38	135
Cranston	1,734	1,241	173	302	292	767
Cumberland	540	160	43	30	15	88
East Greenwich	81	75	30	39	25	94
East Providence	2,352	732	145	184	140	469
Exeter	149	20	NA	NA	NA	NA
Foster	109	24	3	5	2	10
Glocester	265	56	5	6	2	13
Hopkinton	154	41	1	0	0	1
Jamestown	55	12	4	4	4	12
Johnston	587	387	41	59	69	169
Lincoln	270	219	105	148	37	290
Little Compton	47	8	0	0	1	1
Middletown	542	92	43	88	36	167
Narragansett	333	89	21	26	8	55
Newport	1,489	980	82	104	109	295
New Shoreham	13	3	0	0	2	2
North Kingstown	590	278	44	56	81	181
North Providence	729	443	37	47	24	108
North Smithfield	141	31	9	21	27	57
Pawtucket	6,851	3,273	315	515	820	1,650
Portsmouth	190	61	14	9	12	35
Providence	16,851	14,499	1,194	1,580	2,214	4,988
Richmond	142	56	0	2	0	2
Scituate	166	29	13	16	4	33
Smithfield	170	77	40	57	31	128
South Kingstown	377	197	37	56	68	161
Tiverton	290	98	6	19	2	27
Warren	488	163	36	47	32	115
Warwick	2,244	887	150	231	385	766
Westerly	657	301	43	65	48	156
West Greenwich	109	23	20	13	8	41
West Warwick	1,363	676	127	199	107	433
Woonsocket	3,572	2,299	130	211	195	536
Out-of-State	0	0	33	53	88	174
Core Cities	32,435	24,389	1,795	2,461	3,390	7,646
Remainder of State	16,476	5,378	1,276	1,893	1,599	4,768
Rhode Island	50,216	29,767	3,071	4,354	4,989	12,414

**FIP is the Family Independence Program*

Notes to Table

The total number of child care subsidies listed in the pie chart on page 90 differs from the total reported in Table 24 because the pie chart uses data on authorized payments while Table 24 uses payroll data which includes children for whom retroactive payments were made in December.

Parents who are working and are enrolled in the Family Independence Program can claim a "child care disregard." When DHS calculates cash benefits levels based on monthly income, the child care disregard allows families to not count or "disregard" up to $200 of their monthly income which they can designate for child care expenses.

Source of Data for Table/Methodology

The Rhode Island Department of Human Services, INRHODES Database, December 1, 2000. Providence Chamber of Commerce, Options for Working Parents, December 1, 2000.

References for Indicator

[1] Hofferth, S.L. (1996). "Child Care in the U.S. Today" in *The Future of Children: Financing Child Care*. Los Alitos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[2] *Access to Child Care for Low-Income Working Families* (1999). Washington, DC: U.S. Department of Health and Human Services.

[3] Smith, K. (October 2000). "Who's Minding the Kids? Child Care Arrangements Fall 1995," Washington, DC: U.S. Bureau of the Census, Current Population Reports.

[4,5,11] *Child Care Expenses of America's Families* (2000). Washington, DC: The Urban Institute.

[6] Anderson, P.M. & Levine, P. (2000). "Child Care and Mother's Employment Decisions." In Card, D. & Blank, R. eds. *Finding Jobs*. New York: Russell Sage Foundation.

[7] Cutkin, M.L., Groginsky, S. and Christian, S. (December 1997). *Building Blocks: A Legislator's Guide to Child Care Policy*. Denver, CO: National Conference of State Legislatures.

[8] *Starting Points: Meeting the Needs of Our Youngest Children* (1994). New York: Carnegie Corporation.

[9] *Why Child Care Matters* (1993). New York, NY: The Committee for Economic Development.

[10,12,13] *Rhode Island KIDS COUNT Special Report: Building an Early Care and Education System in Rhode Island* (December 1999). Providence, RI: Rhode Island KIDS COUNT.

[11,13,14] Rhode Island Department of Human Services, December 2000.

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Full-Day Kindergarten

DEFINITION

Full-day kindergarten is the percentage of public school kindergarten children enrolled in a full-day kindergarten program. Full-day kindergarten is defined here as a kindergarten program that operates for at least six hours per day. The numbers do not include children enrolled in private kindergarten programs or in half-day kindergarten programs that offer after-school child care.

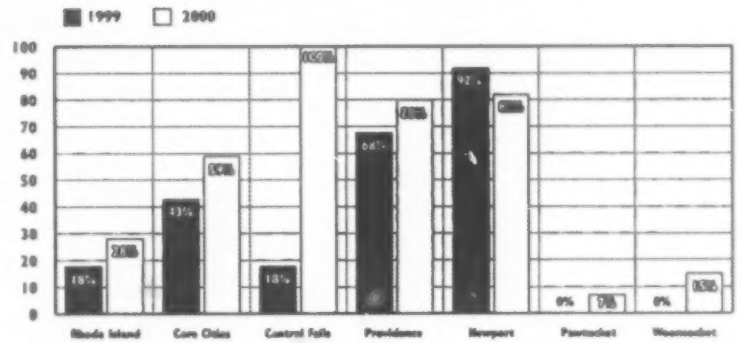
SIGNIFICANCE

Research shows that many children benefit academically and socially from participation in full-day kindergarten as compared to half-day kindergarten programs.[1] The increase in single parent families, the increase in the number of families with both parents working, and the fact that most children have experience with full-day preschool or child care programs has increased the demand for full-day kindergarten. Studies show that parents favor a full-day program that reduces the number of transitions that their kindergarten child must make each day.[2] Full-day kindergarten programs are especially beneficial to children from low-income and educationally disadvantaged backgrounds.[3]

Children in full-day kindergarten have more time to discover at a relaxed pace and interact with their peers, more opportunities to choose activities and develop their own interests, and more time for creative activities.[4] The longer school day allows children and teachers time to explore topics in depth, reduces the ratio of transition time to class time, and provides an environment that supports a child-centered, developmentally-appropriate approach. Full-day kindergartners exhibit more independent learning, classroom involvement, productivity in work with peers, and ability to reflect than half-day kindergartners.[5]

Teachers in full-day programs are better able to assess children's progress.[6] In a full-day program, teachers and school staff have more opportunities to recognize a child's learning style and identify problems or behavioral issues. This allows for more timely intervention, and the potential to reduce costs associated with remedial education and special education costs in later school years.[7]

Children in Full-Day Public Kindergarten Programs, Rhode Island and Core Cities, 1999 and 2000



Source: Rhode Island Department of Elementary and Secondary Education, 1999-2000 and 2000-2001 school year.

◇ In Rhode Island, 28% of children attend full-day kindergarten, an increase from 18% in 1999. Sixteen of Rhode Island's thirty-six school districts offer full-day kindergarten. Of these, four school districts – Central Falls, Middletown, New Shoreham, and Newport – offer universal access to full-day kindergarten. Twelve districts select children for the full-day program by lottery or based on special needs or risk categories.[8]

◇ 59% of children in the core cities attended full-day kindergarten programs in 2000, an increase from 43% in 1999.[9]

◇ Full-day kindergarten helps to level academic disparities among students as they enter the first grade. In a full-day program, teachers have more opportunities to assess and address the needs of children who may come from disadvantaged backgrounds, speak English as a second language, have developmental delays, or have limited experience with formal educational settings.[10]

◇ Research indicates that children who attend full-day kindergarten score higher on first grade reading readiness tests and on reading and achievement tests in the elementary grades.[11]

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Table 25. **Children Enrolled in Full-Day Kindergarten Programs, Rhode Island, 2000-2001**

SCHOOL DISTRICT	TOTAL NUMBER OF CHILDREN ENROLLED IN PUBLIC KINDERGARTEN PROGRAMS	NUMBER OF CHILDREN ENROLLED IN FULL-DAY KINDERGARTEN	% OF CHILDREN ENROLLED IN FULL-DAY KINDERGARTEN
Barrington	194	0	0%
Bristol-Warren	240	16	7%
Burrillville	149	53	36%
Central Falls	274	274	100%
Chariho	263	0	0%
Coventry	376	1	0%
Cranston	706	32	5%
Cumberland	384	0	0%
East Greenwich	141	0	0%
East Providence	364	0	0%
Exeter-W. Greenwich	133	0	0%
Foster	46	0	0%
Foster-Glocester	0	0	0%
Glocester	120	0	0%
Jamestown	58	0	0%
Johnston	270	16	6%
Lincoln	238	0	0%
Little Compton	33	0	0%
Middletown	234	233	100%
Narragansett	113	0	0%
Newport	253	207	82%
New Shoreham	11	11	100%
North Kingstown	329	7	2%
North Providence	179	98	55%
North Smithfield	132	95	72%
Pawtucket	724	50	7%
Portsmouth	189	0	0%
Providence	1,913	1,536	80%
Scituate	108	15	14%
Smithfield	149	0	0%
South Kingstown	242	0	0%
Tiverton	147	0	0%
Warwick	755	44	6%
Westerly	267	75	28%
West Warwick	257	51	20%
Woonsocket	495	75	15%
Core Cities	*3,659*	*2,142*	*59%*
Remainder of State	*6,827*	*747*	*11%*
Rhode Island	*10,486*	*2,889*	*28%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 2000. Data are as of October 2000 and are for the 2000-2001 school year.

Core Cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

References for Indicator

[1,2,3] Rothenburg, D. (May, 1995). *"Full-Day Kindergarten Programs."* ERIC Clearinghouse on Elementary and Early Childhood Education, ERIC DIGESTS.

[1,2,3] *Learning to Learn: Full-Day Kindergarten for At-Risk Kids* (July, 1999). Harrisburg, PA: Pennsylvania Partnership for Children.

[4] Elicker, J. and Mathur,S. (1997). "What Do They Do All Day? Comprehensive Evaluation of a Full-Day Kindergarten." *Early Childhood Research Quarterly*, 12(4). Indianapolis, IN: Department of Child Development and Family Studies, Purdue University.

[5] National Association of School Psychologists (1997). *Full-day Versus Half-day Kindergarten Programs: A Brief History and Synopsis.*

[6] Rhode Island Department of Elementary and Secondary Education, 1999-2000 and 2000-2001 school years.

English Language Learners

DEFINITION

English language learners are public school children (Kindergarten through grade 12) who are receiving English as a Second Language services or Bilingual Education services in Rhode Island public elementary and secondary schools. Children in public school pre-kindergarten programs are not included. The term "Limited English Proficient students" has been replaced by the term "English language learners" in the education community.

SIGNIFICANCE

In 1998 there were 97,435 foreign-born individuals residing in Rhode Island. Of these, 6,641 were children under the age of 18, about 3% of the child population in the state.[1] A far greater number of Rhode Island children live in households headed by an immigrant. In 1998, immigrants headed 45,674 Rhode Island households with children under 18.[2]

Children of recent immigrants are at very high risk for difficulties at school. They face multiple risk factors including poverty, non-English speaking backgrounds, low educational level of parents, and discrimination based on race, ethnic background, culture, or language.[3] Adults who report that they have some difficulty with English are twelve times as likely to have completed less than five years of schooling and half as likely to have graduated from high school. Children who live in these households are fifty percent more likely to live in poverty.[4] These children are also most likely to be concentrated in underresourced schools in high poverty communities.[5]

Schools have been among the most dramatically affected of all public agencies by the increase in immigrant children and children of immigrants. Schools play a critical role in helping children to transition to a new culture and in providing an education that supports academic success for children with a primary language other than English.[6]

There are currently 10,193 school-aged Rhode Island children who are English language learners, 7% of all students enrolled statewide. These children include both foreign-born and second-generation children. 90% of these students are concentrated in six communities across the state. More than half (57%) attend Providence schools, 12% attend Pawtucket schools, and 10% attend schools in Central Falls. Cranston, East Providence and Woonsocket each have 4% of the state's students with limited English proficiency.[7]

Rhode Island State Regulations for English Language Learners

In September 2000, the State of Rhode Island issued new regulations for English Language Learners (formerly termed Limited English Proficient students). Highlights from the regulations include:

◇ Programs will be developmental (not remedial) and be comparable in structure and content to instruction provided to English-proficient students.

◇ Programs will focus on full English language literacy, including ability in listening, speaking, reading, and writing appropriate to age/grade level.

◇ Programs will provide for a pupil/teacher ratio lower than the mainstream education program, with a suggested class size of 15 students per English as Second Language (ESL) teacher. Programs will employ certified ESL teachers.

◇ Programs will have a process for evaluating the adequate yearly progress of each English Language Learner. The performance of all exited students shall be monitored for a minimum of two years to determine success in regular education placement.

Source: Rhode Island Department of Elementary and Secondary Education, Limited English Proficiency (LEP) Regulations Chapter 16-54 2000.

Language and Literacy

◇ Children who are English language learners need developmental programs that begin with accurately assessing each child's abilities and knowledge in their own language.[8] Effective programs for English language learners are structured to comprehensively address the sociocultural processes of acclimating to a new culture.[9]

◇ A major barrier to the development of proficiency in English is the absence of books in the lives of many students from low-income and immigrant families.[10] Access to books in the child's primary language as well as in English is a critical tool to improve language development and literacy.[11,12,13]

Table 26.

English Language Learners, Rhode Island, 1999-2000

SCHOOL DISTRICT	TOTAL ENROLLMENT	KINDERGARTEN	ELEMENTARY SCHOOL (GRADES 1-5)	MIDDLE SCHOOL (GRADES 6-8)	HIGH SCHOOL (GRADES 9-12)	NUMBER OF ENGLISH LANGUAGE LEARNERS (ELL)	ELL AS % OF TOTAL ENROLLMENT
Barrington	3,103	0	0	0	0	0	0%
Bristol-Warren	3,772	19	109	11	6	145	4%
Burrillville	2,708	0	2	0	0	2	0%
Central Falls	3,312	106	504	183	179	972	29%
Charlho	3,722	1	2	2	4	9	0%
Coventry	5,473	1	6	3	4	14	0%
Cranston	10,620	54	198	103	93	448	4%
Cumberland	4,954	12	69	21	13	115	2%
East Greenwich	2,292	3	4	2	1	10	0%
East Providence	6,439	54	227	68	69	418	6%
Exeter-W. Greenwich	2,015	0	6	5	1	12	1%
Foster	388	0	0	0	0	0	0%
Foster-Glocester	1,576	0	0	0	0	0	0%
Glocester	782	0	1	0	0	1	0%
Jamestown	803	0	0	0	0	0	0%
Johnston	3,415	0	17	18	10	45	1%
Lincoln	3,667	0	23	2	8	33	1%
Little Compton	452	0	0	0	0	0	0%
Middletown	2,725	1	23	10	11	45	2%
Narragansett	1,745	0	13	2	2	17	1%
Newport	2,964	0	42	18	8	68	2%
New Shoreham	125	0	4	0	0	4	3%
North Kingstown	4,200	9	25	15	14	63	2%
North Providence	3,538	0	48	9	30	87	2%
North Smithfield	1,791	0	0	0	0	0	0%
Pawtucket	9,656	90	573	274	263	1,200	12%
Portsmouth	2,748	0	2	2	0	4	0%
Providence	26,004	808	3,420	856	687	5,771	22%
Scituate	1,726	0	0	0	0	0	0%
Smithfield	2,681	0	0	0	0	0	0%
South Kingstown	4,157	6	19	12	14	51	1%
Tiverton	2,122	0	0	0	0	0	0%
Warwick	11,915	8	48	12	8	76	1%
Westerly	3,483	10	26	4	13	53	2%
West Warwick	3,695	19	48	13	23	103	3%
Woonsocket	6,690	54	234	64	28	380	6%
Core Cities	*48,626*	*1,058*	*4,773*	*1,395*	*1,165*	*8,391*	*17%*
Remainder of State	*103,913*	*197*	*920*	*314*	*371*	*1,802*	*2%*
Rhode Island	*152,539**	*1,255*	*5,693*	*1,709*	*1,536*	*10,193*	*7%*

**Includes 1,081 students enrolled in state-run schools including Davies Vocational, Metropolitan Career Tech, and Rhode Island School for the Deaf.*

Note to Table

There are an additional 44 Rhode Island children in public pre-kindergarten programs who are English Language Learners and enrolled in English as Second Language or Bilingual Education Programs.

Sources of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 1999-2000 school year. Total number of English Language Learners is the number of students in each district who were actively enrolled in English as a Second Language (ESL) or Bilingual Education Programs in the 1999-2000 school year. Students who are not yet fully English proficient but have exited the ESL or bilingual program to regular education are not included in these numbers.

References

[12] US Census Bureau, Current Population Survey, 1996-2000 average.

[3] *Information Works!* (2000). Providence, RI: Rhode Island Department of Elementary and Secondary Education and University of Rhode Island, National Center on Public Education and Social Policy.

[4] Crawford, James (1997). *Best Evidence: Research Foundations for the Bilingual Education.* Washington, DC: National Clearinghouse for Bilingual Education.

[56] Ruiz-de-Velasco, J. and Fix, M. (2001). *Overlooked and Underserved: Immigrant Students in U.S. Secondary Schools.* Washington, DC: Urban Institute.

[7] Rhode Island Department of Elementary and Secondary Education, 1999-2000 school year.

[89] Collier, V. (Fall 1995). "Acquiring a Second Language for School" in *Directions in Language and Education* Vol. 1 No.4. Washington, DC: National Clearinghouse for Bilingual Education.

[10][11] Krashen, S. (1997). "Why Bilingual Education?" in *ERIC Digest.* Champaign, IL: ERIC Clearinghouse on Rural Education and Small Schools.

[12] *America's Children: Key Indicators of Child Well-Being* (2000). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[13] High, P. and Hopmann, M (April 1999). "Child Centered Literacy Orientation: A Form of Social Capital?" *Pediatrics,* Vol. 103, No. 4.

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Children Enrolled in Special Education

DEFINITION

Children enrolled in special education is the number of children ages 3 to 22 who are enrolled in special education in Rhode Island elementary and secondary schools.

SIGNIFICANCE

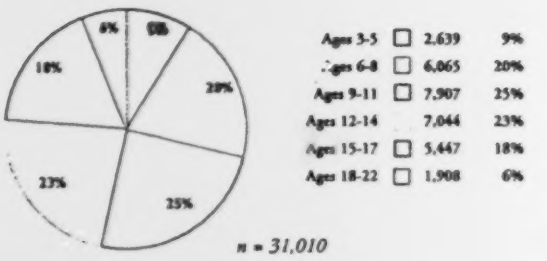
Most children with disabilities have a limitation caused by one or more chronic physical conditions, cognitive conditions, or significant impairments in social, emotional or behavioral functioning in comparison with their peers of the same age.[1] Whether disabilities are mild or severe, they have the potential to create special needs related to physical health, mental health, education, parent support, child care, recreation, and career preparation.[2]

Children with disabilities are a heterogeneous group, varying by type of disability and age of the child, as well as by the many differences in the population at large – such as family income, race, ethnicity, primary language, and parents' educational level.[3] While there are wide variations in the specific needs of each child, there are some issues of common concern.[4] Children with disabilities need access to health care that is appropriate to their special needs. Children who meet certain disability criteria are eligible for Medicaid and/or cash assistance through the Supplemental Security Income (SSI) program.[5] Some children with disabilities may require costly therapeutic and health care services, wheelchairs, or home modifications. Because many services are not fully-covered by insurance, families from all income levels can incur serious financial burdens.

Local school systems are responsible for identifying and evaluating students ages 3 to 22 who they have reason to believe are students with disabilities and therefore might require special education and related services.[6] Between 1976-1977 and 1993-1994, states experienced an increase of over 70% in the number of school-age children served in special education. This increase is almost entirely attributable to the growth in the number of children identified as having specific learning disabilities.[7]

In the 1999-2000 school year, there were 31,010 Rhode Island children (20% of the student population) who received special education services. Of these, 53% were classified as learning disabled; 20% speech disorders; 8% behavioral disorders; 8% other health-impaired; 4% developmentally delayed; 4% mentally retarded; and 4% other disabilities.[8]

Special Education, By Age, Rhode Island, School Year 1999-2000



Source: The Rhode Island Department of Elementary and Secondary Education, Office of Special Education, June 30, 2000.

Inclusion of Students with Disabilities

◇ An Individualized Education Plan (IEP) is required for all students with a disability or suspected disability. The IEP is a detailed description of the exact steps which must be taken to provide a free and appropriate education to the student. The IEP is designed with input from school staff, specialists as needed, and the student's parent or guardian.[9]

◇ The services described in the IEP must be provided in the least restrictive environment, i.e. to the extent appropriate to the child's needs, the child should receive special services in a setting that is integrated with other children, with and without disabilities. This is sometimes referred to as "inclusion" or "mainstreaming." However, the inclusion is not mandated unless it is appropriate to the needs of the child.[10]

◇ Inclusion is meant to raise expectations for student performance, provide opportunities for children with disabilities to learn alongside their nondisabled peers, improve coordination between regular and special educators, and increase school-level accountability for performance.[11]

◇ Between 1986 and 1996 in the U.S., the percentage of students with disabilities who were educated in regular classrooms increased by 20%, while the percentage served in resource rooms, separate classes, and separate residential facilities decreased.[12]

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Table 27

Children and Youth in Special Education, by Primary Disability, Ages 3-22, Rhode Island, 2000

SCHOOL DISTRICT	TOTAL # OF STUDENTS	BEHAVIORALLY DISORDERED	MENTALLY RETARDED	ORTHOPEDICALLY IMPAIRED	HEALTH IMPAIRED	LEARNING DISABLED	SPEECH DISORDER	DEVELOPMENTALLY DELAYED	OTHER	TOTAL STUDENTS WITH DISABILITIES	% STUDENTS IN SPECIAL EDUCATION
Barrington	3,103	39	17	1	21	274	140	18	25	535	17%
Bristol-Warren	3,772	50	49	7	23	456	170	34	20	809	21%
Burrillville	2,708	77	27	0	77	262	123	14	22	602	22%
Central Falls	3,312	88	50	5	32	463	86	46	19	789	24%
Chariho	3,722	49	15	8	51	321	165	23	32	664	18%
Coventry	5,473	80	54	6	45	741	140	57	21	1,144	21%
Cranston	10,620	95	35	8	122	1,512	367	53	48	2,240	21%
Cumberland	4,954	100	30	6	242	321	304	40	47	1,090	22%
East Greenwich	2,292	36	5	6	68	157	99	16	30	417	18%
East Providence	6,439	114	75	2	231	434	329	37	49	1,271	20%
Exeter-W. Greenwich	2,015	37	10	6	96	93	131	12	8	393	20%
Foster	388	2	0	0	2	11	31	3	1	50	13%
Foster-Glocester	1,576	16	9	1	19	168	35	0	5	253	16%
Glocester	782	5	4	1	13	55	76	14	9	177	23%
Jamestown	803	2	3	2	26	62	26	4	8	133	17%
Johnston	3,415	39	24	2	69	432	195	27	14	802	23%
Lincoln	3,667	43	27	2	120	252	114	48	39	645	18%
Little Compton	452	5	2	0	3	45	22	1	1	79	17%
Middletown	2,725	41	13	0	50	286	142	11	20	563	21%
Narragansett	1,745	37	3	2	51	188	118	10	13	422	24%
Newport	2,964	81	13	14	15	473	107	34	13	750	25%
New Shoreham	125	3	0	0	0	10	13	2	0	28	22%
North Kingstown	4,200	42	9	7	22	411	220	16	14	741	18%
North Providence	3,538	64	16	5	87	290	171	25	20	678	19%
North Smithfield	1,791	18	8	1	49	153	86	13	15	343	19%
Pawtucket	9,656	213	140	6	93	891	458	152	57	2,010	21%
Portsmouth	2,748	22	9	3	56	197	196	4	27	514	19%
Providence	26,004	282	259	13	24	3,428	501	132	75	4,714	18%
Scituate	1,726	7	3	2	32	108	118	10	10	290	17%
Smithfield	2,681	14	7	4	52	209	122	14	17	439	16%
South Kingstown	4,157	74	23	6	60	394	246	18	26	847	20%
Tiverton	2,122	25	8	2	29	213	131	5	14	427	20%
Warwick	11,915	212	76	19	227	1,471	345	233	81	2,664	22%
Westerly	3,483	63	6	5	75	350	219	23	31	772	22%
West Warwick	3,695	90	14	4	14	450	170	39	20	801	22%
Woonsocket	6,690	203	144	7	262	615	239	75	63	1,608	24%
State Run Schools	*1,081*	*12*	*5*	*1*	*8*	*140*	*14*	*0*	*126*	*306*	*28%*
Core Cities	*48,626*	*867*	*606*	*45*	*426*	*5,870*	*1,391*	*439*	*227*	*9,871*	*20%*
Remainder of State	*103,913*	*1,513*	*586*	*119*	*2,040*	*10,466*	*4,778*	*824*	*813*	*21,139*	*20%*
Rhode Island	*152,539*	*2,380*	*1,192*	*164*	*2,466*	*16,336*	*6,169*	*1,263*	*1,040*	*31,010*	*20%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 1999-2000 school year. Office of Special Education, June 30, 2000.

Number of students is the "resident average daily membership" as calculated by the RI Department of Elementary and Secondary Education.

"Other" includes deaf and blind, visually impaired or blind, multi-handicapped, autistic, and traumatic brain injury.

Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

The denominator is the number of students enrolled in the school district.

"State-Run Schools" include Davies Vocational Technical School, Metropolitan Career Tech and Rhode Island School for the Deaf. The Training School is not included.

References

[1] Rhode Island Department of Health, Disability and Health Program, 1998.

[2a] Martin, E.W., Martin, R. and Terman, D.L. "The Legislative and Litigation History of Special Education" in *Special Education for Students with Disabilities* (Spring 1996). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[2b,3,4] Terman, D.L., Larner, M.B., Stevenson, C.S., Behrman, R.E. "Special Education for Students with Disabilities" in *Special Education for Students with Disabilities* (Spring 1996). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[5] *Social Security: Supplemental Security Income* (July 1998, Informational Brochure). Washington, DC: Social Security Administration.

[7] Lewit, E.M., Schuurman Baker, L. "Children in Special Education" in *Special Education for Students with Disabilities* (Spring 1996). Los Altos, CA: Center for the Future of Children, David and Lucile Packard Foundation.

[8] Rhode Island Department of Elementary and Secondary Education, Office of Special Education, June 30, 2000.

[9,10] "Quality of Education Environments" (1999) in *The Condition of Education*. Washington, DC: National Center for Education Statistics.

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Fourth-Grade Reading Skills

DEFINITION

Fourth-grade reading skills is the percentage of fourth-grade students who scored at or above the proficiency level for reading in the New Standards English Language Arts Reference Exam in 2000. The exam is made up of two parts: Basic Understanding focuses on the student's ability to comprehend and understand text, and Interpretation and Analysis focuses on the student's ability to correctly interpret and analyze text.

SIGNIFICANCE

Reading skills are critical to a student's success in school and in the workforce. Students who cannot read are more likely to be absent from school, exhibit behavior problems, have low levels of self-confidence, and perform poorly in school.[1] Parent education, language proficiency, family structure, and the community's socioeconomic status are strong predictors of student achievement in reading.[2,3,4]

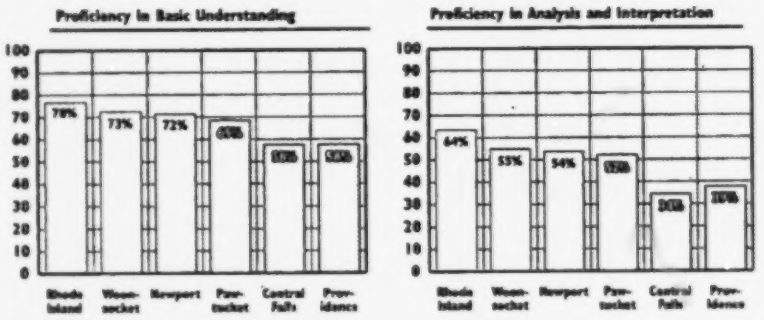
In the U.S., Hispanic children face the most barriers to reading proficiency because they are more likely to be poor, less likely to attend pre-school, and more likely to have parents that have not finished high school.[5]

Low-income children start first grade with fewer vocabulary words than middle class children.[6] Effective curricula include explicit comprehension strategies (such as summarizing the main ideas) and help build the child's background knowledge and vocabulary.[7]

Literacy begins long before children encounter formal school instruction in writing and reading. Reading to young children at home and participation in pre-school programs are two factors that make a difference in reading achievement and overall success in school.[8] Young children who attend Head Start, pre-kindergarten, or other center-based preschool programs have higher emerging literacy scores than other 4 year-olds.[9]

A home environment which encourages learning and parents that are involved in their children's education are important factors in school achievement.[10] According to the National Education Goals Panel, children who report that they regularly read for fun on their own time consistently outperform students who read only what is required of them at school. Children who regularly discuss their reading with family and friends score significantly higher in reading than students who report that they rarely or never do so.[11] Student reading proficiency declines as television viewing increases. Nationally, 18% of fourth graders watch six or more hours of television daily.[12]

Rhode Island Public School 4th Grade Reading Proficiency, Core Cities and Rhode Island, 1999-2000



◇ In 2000, 78% of Rhode Island fourth-graders scored at or above reading proficiency in *Basic Understanding* and 64% scored at or above proficiency in *Analysis and Interpretation.* In 2000, each of the five core cities had reading proficiency levels below the state rates.

Source: RI Department of Elementary and Secondary Education, New Standards English Language Arts Reference Exam at Grade 4, 1999-2000 school year.

Preschool and the Early Grades

◇ Children's academic achievement can be improved through community-wide efforts that set high standards for achievement, provide supportive environments for parenting, provide access to high-quality early care and education programs, and have a variety of out-of-school learning opportunities for adults and children.[13]

◇ High-quality preschools and elementary schools can boost literacy skills by helping children learn, think, and talk about new areas of knowledge; by integrating reading, writing, letters, sounds, and storytelling into everyday activities; and by offering opportunities to play in ways that build awareness of the sounds and structure of language.[14]

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Table 28.

Fourth-Grade Reading Proficiency, Rhode Island, 1999-2000

SCHOOL DISTRICT	COMMUNITY CONTEXT: % ADULTS COMPLETING HIGH SCHOOL	% CHILDREN IN POVERTY	% LIMITED ENGLISH PROFICIENCY	NUMBER OF 4TH GRADE TEST TAKERS	% OF 4TH GRADE STUDENTS MEETING STANDARD FOR BASIC UNDERSTANDING	% OF 4TH GRADE STUDENTS MEETING STANDARD FOR ANALYSIS & INTERPRETATION
Barrington	89%	2.3%	0%	229	93%	80%
Bristol-Warren	NA%	13.6%	4%	341	75%	62%
Burrillville	71%	7.0%	0%	196	77%	64%
Central Falls	47%	35.7%	28%	303	58%	34%
Chariho	82%	8.7%	0%	279	90%	73%
Coventry	74%	7.5%	0%	433	85%	70%
Cranston	74%	10.9%	4%	896	88%	78%
Cumberland	75%	4.8%	2%	450	89%	79%
East Greenwich	90%	3.7%	0%	194	91%	85%
East Providence	67%	9.7%	7%	547	78%	63%
Exeter-W. Greenwich	78%	6.5%	0%	183	86%	73%
Foster	82%	11.3%	0%	77	82%	73%
Foster-Glocester	83%	8.3%	0%	NA	NA	NA
Glocester	83%	10.8%	0%	166	93%	79%
Jamestown	89%	10.3%	0%	80	86%	75%
Johnston	67%	10%	1%	323	84%	69%
Lincoln	76%	9.5%	1%	312	83%	75%
Little Compton	86%	3.5%	0%	44	95%	84%
Middletown	85%	6.8%	2%	215	86%	70%
Narragansett	87%	7.8%	1%	143	86%	79%
Newport	84%	22.1%	2%	237	72%	54%
New Shoreham	94%	9.5%	3%	18	83%	83%
North Kingstown	86%	6.9%	1%	363	90%	79%
North Providence	71%	7.4%	2%	283	88%	73%
North Smithfield	72%	1.4%	0%	132	92%	77%
Pawtucket	62%	17.6%	12%	924	69%	[illegible]%
Portsmouth	86%	6.0%	0%	249	85%	73%
Providence	63%	40.9%	21%	2,306	58%	39%
Scituate	84%	5.3%	0%	166	92%	86%
Smithfield	81%	4.5%	0%	224	93%	83%
South Kingstown	86%	9.0%	1%	345	88%	77%
Tiverton	71%	8.5%	0%	176	87%	74%
Warwick	78%	9.0%	1%	983	83%	69%
Westerly	76%	9.6%	2%	293	88%	76%
West Warwick	70%	16.7%	3%	287	82%	70%
Woonsocket	56%	22.3%	6%	561	73%	55%
Core Cities	*NA*	*31.4%*	*17%*	*4,331*	*NA*	*NA*
Remainder of State	*NA*	*8.5%*	*2%*	*8,637*	*NA*	*NA*
Rhode Island	*72%*	*15.8%*	*7%*	*12,968*	*78%*	*64%*

Source of Data for Table/Methodology

Percentage of adults completing high school are based on U.S. Bureau of the Census, 1990 Census of Population.

Percentage of children in poverty is from the U.S. Census Bureau, Small Area Income and Population Estimates, Children Ages 5 to 17, 1997. Released November 2000.

All other data are from the RI Department of Elementary and Secondary Education, 2000.

Core cities are Providence, Pawtucket, Central Falls, Woonsocket and Newport.

NA: Community has a regional high school.

References for Indicator

[1] *Wasting America's Future* (1994). Washington, DC: The Children's Defense Fund.

[2,3] *The National Education Goals Report: Building a Nation of Learners* (1995). Washington, DC: U.S. Government Printing Office.

[3] Zill, N., Collins, M., West, J., & Hausken, E.G. (1995). *Approaching Kindergarten: A Look at Preschoolers in the United States.* Young Children 51: 35-38.

[4] America's Children: Key National Indicators of Well-Being (2000). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[5,13] *Years of Promise: A Comprehensive Learning Strategy for America's Children.* (1996). New York: Carnegie Corporation of New York.

[5] Fletcher, M.A., "Latinos at the Back of the Class" in *Washington Post* (December 1998), based on a report by the National Council of La Raza.

[6] Schulman, K., Blank, H., and Ewen, D. (1999). *Seeds to Success: State Prekindergarten Initiatives, 1998-1999.* Washington, D.C.: Children's Defense Fund.

[11] *Trends in the Well-Being of America's Children and Youth: 1999* (1999). Washington, DC: U.S. Child Trends Inc., Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

[13] *Years of Promise: A Comprehensive Learning Strategy for America's Children* (1996). New York: Carnegie Corporation of New York.

[3,14] *Starting Out Right: A Guide to Promoting Children's Reading Success* (1998). Washington, DC: The National Academy Press.

School Attendance

DEFINITION

School attendance is the average daily attendance of public school students in elementary school (grades 1-5), middle school (grades 6-8), and high school (grades 9-12) for each public school district in Rhode Island. Public school students in preschool, kindergarten, and ungraded classrooms are not included.

SIGNIFICANCE

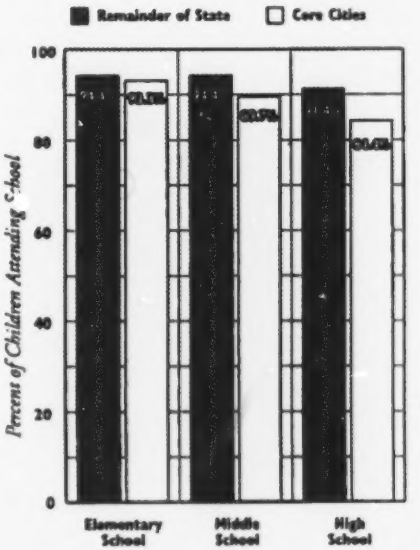
Poor school attendance affects school achievement for young children as well as teenagers. Younger children miss the opportunity to develop important academic skills and to make connections with peers and teachers. Lower attendance rates are linked to lower reading scores and are an important factor in variation in states' mathematics scores.[1,2] These academic and social delays can result in a child's failure to advance to the next grade level and lead to the repeating of grades. High school students who habitually miss school are more likely to dropout, which in turn affects their future employment potential and career opportunities.[3] Truancy among teens is a powerful predictor of juvenile delinquency.[4]

Problems with student attendance create a climate of instability in schools. In schools where truancy rates are low, there is less disruption and violence. Teachers are more committed to students and are more likely to interact and engage with the entire class. Students are less likely to miss school where they are engaged and have a sense of belonging.[5]

Student absenteeism places individual children at risk for school failure. Failure to attend school is often the first sign to parents and schools that a child is in trouble.[6] Children miss school for a variety of reasons. Instability at home resulting from frequent residential moves and family crisis or a parent's illness often contributes to poor attendance.[7] Teens report that a sense of failure, alienation from school, irrelevant courses and suspensions are involved in their decisions to skip school.[8,9] Poor attendance may also signal drug use, emotional and mental health problems, and peer pressure to miss school.[10]

Effective truancy reduction strategies include clear, consistently enforced school policies; school reorganization to support students' engagement in learning and attachment to school; effective communication between the school and the parent; family counseling programs; and collaboration between school and community partners.[11]

School Attendance Rates, by Grade Levels, Rhode Island and the Core Cities, 1999-2000



◇ There are more than 10,896 students attending high school in the core cities. Each 1% decrease in the high school attendance rate for the core cities means that 109 fewer high school students are attending school each day.

Source: Rhode Island Department of Elementary and Secondary Education, 1999-2000 school year.

Programs to Increase School Attendance and Reduce Truancy

◇ Successful programs to increase school attendance are coordinated by committed multi-disciplinary teams that take into account the specific needs of each child and their family, and seek alternatives to suspension.[12]

◇ The newly established Rhode Island Truancy Court Program is designed to help students with 10 or more unexcused absences and at risk of delinquent behavior. The goal is to identify the child's needs and address them with appropriate treatment, mentoring, tutoring, and other services.[13]

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School Attendance Rate, Rhode Island, 1999-2000

Table 29.

SCHOOL DISTRICT	# ENROLLED ELEMENTARY SCHOOL	ATTENDANCE RATE	# ENROLLED MIDDLE SCHOOL	ATTENDANCE RATE	# ENROLLED HIGH SCHOOL	ATTENDANCE RATE
Barrington	1,335	96.2%	744	95.7%	892	94.2%
Bristol-Warren	1,534	94.9%	909	92.5%	1,158	89.0%
Burrillville	1,052	95.5%	674	94.5%	888	92.7%
Central Falls	1,510	93.6%	797	91.1%	820	86.8%
Chariho	1,528	95.5%	938	95.0%	1,081	93.6%
Coventry	2,179	96.1%	1,383	95.0%	1,658	90.7%
Cranston	4,346	95.9%	2,584	93.3%	2,954	88.9%
Cumberland	2,046	96.3%	1,201	96.1%	1,367	92.9%
East Greenwich	953	96.6%	594	96.0%	652	95.2%
East Providence	2,573	95.8%	1,590	92.5%	1,897	88.9%
Exeter-W. Greenwich	809	95.9%	539	95.7%	585	92.0%
Foster	359	95.8%	NA	NA	NA	NA
Foster-Glocester	NA	NA	687	94.0%	885	91.4%
Glocester	712	96.1%	NA	NA	NA	NA
Jamestown	367	95.6%	200	95.5%	189	93.7%
Johnston	1,529	95.6%	843	92.9%	893	83.8%
Lincoln	1,508	96.7%	945	95.4%	1,055	93.8%
Little Compton	235	94.9%	112	93.8%	99	91.9%
Middletown	1,108	95.9%	579	94.5%	723	92.8%
Narragansett	710	94.4%	435	94.3%	530	92.6%
Newport	1,167	93.9%	593	90.9%	777	89.6%
New Shoreham	57	94.7%	22	90.9%	38	89.5%
North Kingstown	1,811	96.0%	1,042	94.8%	1,126	92.7%
North Providence	1,463	95.8%	935	95.0%	935	87.4%
North Smithfield	757	96.3%	407	96.3%	494	94.3%
Pawtucket	4,135	94.6%	2,227	92.8%	2,036	86.6%
Portsmouth	1,136	95.6%	672	95.1%	822	94.8%
Providence	11,085	92.5%	5,338	87.3%	5,570	81.7%
Scituate	701	96.1%	387	94.8%	563	93.4%
Smithfield	1,053	96.3%	691	94.5%	801	93.1%
South Kingstown	1,701	95.8%	1,005	95.2%	1,259	93.4%
Tiverton	846	95.5%	548	93.4%	630	91.0%
Warwick	4,585	95.6%	3,021	94.4%	3,671	92.0%
Westerly	1,405	95.7%	828	94.8%	1,081	93.5%
West Warwick	1,552	94.8%	889	92.4%	1,070	88.7%
Woonsocket	2,609	93.9%	1,457	92.7%	1,693	87.5%
Core Cities	*20,506*	*93.3%*	*10,412*	*89.7%*	*10,896*	*84.4%*
Remainder of State	*41,950*	*94.4%*	*25,404*	*94.4%*	*29,996*	*91.4%*
Rhode Island	*62,456*	*94.1%*	*35,816*	*93.0%*	*40,892*	*89.5%*

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 1999-2000 school year.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the total number of students enrolled in the school district.

References for Indicator

[12] *A Report from the Kids Mobility Project* (March 1998). Minneapolis, MN: The Kids Mobility Project.

[1] "Indicator 42: Student Absenteeism and Tardiness" (1996). *The Condition of Education.* Washington, DC: National Center for Education Statistics.

[2,3,4] "*Urban Policies and Programs to Reduce Truancy*" (1997). Clearinghouse on Urban Education, *ERIC Digest*, November 1999.

[5,6,7] *Manual to Combat Truancy: The Problem of Truancy in America's Communities* (July 1996). Washington, DC: U.S. Department of Education and U.S Department of Justice.

[7,8,9] "Student Truancy" *ERIC Digest* (1999). Clearinghouse on Education Management.

[9] Jeremiah, S. J. (Hon.) (December 2000) "Truancy Court: A Child of the Juvenile Justice System" in *Rhode Island Bar Journal.* Providence, RI: Rhode Island Bar Association.

Suspensions

DEFINITION

Suspensions are the number of infractions and disciplinary actions for Rhode Island public school students – kindergarten through twelfth grade – during the 1999-2000 school year. Disciplinary actions include in-school suspensions, out-of-school suspensions, alternative placements, and expulsions.

SIGNIFICANCE

Effective school discipline strategies focus on ensuring the safety of students and staff, encouraging responsible behavior, and creating an environment conducive to learning.[1] The most common discipline problems in schools involve non-criminal student behavior that is disruptive of the learning environment. Serious student misconduct involving violent and criminal behavior is relatively infrequent and has declined between 1995 and 1999, but may have immediate and long-lasting impact on the quality of the school environment.[2,3]

Schools may take any number of actions when a student is disruptive or threatens the safety and learning of other students. Ninety-four percent of public schools report having "zero-tolerance" policies for firearms and more than three quarters of U.S. schools have such policies for other serious offenses such as violence, use of tobacco, alcohol, or drugs, or possession of weapons.[4,5]

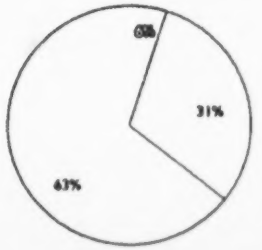
Students who dislike school, do poorly academically, and have limited career objectives are more likely to be disruptive.[6] Students who are suspended from school are at higher risk for poor academic achievement. A recent national study found that students in grades 8-12 who had committed minor infractions (such as cutting class or tardiness) or more serious offenses (such as fighting or physically abusing a teacher) scored 10 percent lower on achievement tests in mathematics, reading, social science and science than students who did not have discipline problems.[7] Students who have discipline problems are more likely to drop out of school.[8]

Discipline problems are likely to be reduced when schools work to ensure academic success for low-achievers while increasing their involvement and attachment to school.[9] African-American students are more likely to be suspended or expelled from school than are White students. In Providence, in 1997-1998, African-American students made up 23% of the student population and were 39% of the students suspended or expelled, while White students made up 21% of the student population and were 13% of the students suspended or expelled.[10]

Disciplinary Actions, Rhode Island Public Schools, 1999-2000

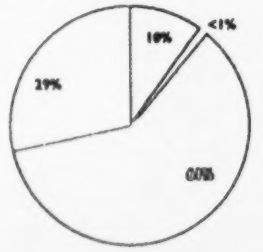
By Grade Level

6%	Elementary School (Pre K-5)
31%	Middle School (6-8)
63%	High School (9-12)



By Category

61%	Out-of-School Suspensions
29%	In-School Suspensions
10%	Alternative Program Placement
<1%	Expulsions



◇ During the 1999-2000 school year, there were 43,840 incidents in which a Rhode Island public school student received a suspension, alternative program placement, or expulsion. The 43,840 suspensions can be attributed to 15,502 students.

By Type of Infraction	Number	By Type of Infraction	Number
Minor Offenses*	30,971	Drug Offenses	407
Disorderly Conduct	4,945	Larceny/Theft	349
Fighting	2,920	Weapon Possession	207
Assault	1,602	Vandalism	310
Possession or Use of Tobacco	1,052	Unknown	24
Threat/Intimidation	1,026		

*Examples of minor offenses include cutting class, skipping detention and tardiness.

Source: Rhode Island Department of Elementary and Secondary Education, 1999-2000 school year.

◇ Research shows that the best approach to school discipline is a balance between clearly communicated and consistently enforced rules and a climate of concern for students as individuals.[11] Smaller schools — or dividing larger schools into "schools within schools" — are better able to address the individual needs of students.[12]

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Table 30. **Disciplinary Actions, Rhode Island School Districts, 1999-2000**

SCHOOL DISTRICT	# OF STUDENTS ENROLLED	TYPE OF DISCIPLINARY ACTION: SUSPENDED OUT-OF-SCHOOL	SUSPENDED IN-SCHOOL	ALTERNATE PROGRAM PLACEMENT	EXPELLED	TOTAL DISCIPLINARY ACTIONS
Barrington	3,183	72	34	0	0	106
Bristol-Warren	3,916	918	1,215	0	0	2,133
Burrillville	2,865	385	181	0	0	566
Central Falls	3,358	432	400	0	0	832
Chariho	3,955	1,416	1,592	122	0	3,130
Coventry	5,589	1,000	31	22	0	1,053
Cranston	10,924	3,187	18	0	0	3,205
Cumberland	5,135	457	32	2	0	491
East Greenwich	2,374	187	531	0	0	718
East Providence	6,623	640	5	0	0	645
Exeter-W. Greenwich	2,062	201	22	1	1	225
Foster	408	0	0	0	0	0
Foster-Glocester	1,586	357	1	1	0	359
Glocester	850	0	0	0	0	0
Jamestown	658	1	0	0	0	1
Johnston	3,524	875	15	1	2	893
Lincoln	3,702	312	683	37	0	1,032
Little Compton	348	0	0	0	0	0
Middletown	2,833	421	1,239	6	0	1,666
Narragansett	1,804	235	33	0	0	268
Newport	2,965	755	8	1	0	764
New Shoreham	126	1	0	0	0	1
North Kingstown	4,504	343	78	0	0	421
North Providence	3,518	686	12	0	2	700
North Smithfield	1,819	237	0	0	0	237
Pawtucket	9,904	1,035	27	6	1	1,069
Portsmouth	2,874	76	23	526	0	625
Providence	26,427	4,794	1,404	9	5	6,212
Scituate	1,750	54	904	0	0	958
Smithfield	2,747	234	2	0	0	236
South Kingstown	4,383	480	17	0	0	497
Tiverton	2,297	398	1,893	6	0	2,297
Warwick	12,264	3,336	0	3,832	0	7,168
Westerly	3,605	247	28	0	0	275
West Warwick	3,801	846	1,168	0	0	2,014
Woonsocket	6,670	1,817	965	0	2	2,784
State-Operated	*1,103*	*221*	*2*	*1*	*0*	*224*
Core Cities	*49,324*	*8,833*	*2,804*	*16*	*8*	*11,661*
Remainder of State	*107,130*	*17,823*	*9,759*	*4,557*	*5*	*32,144*
Rhode Island	*156,454*	*26,656*	*12,563*	*4,573*	*13*	*43,805*

Note to Table

Total disciplinary actions is the number of incidents resulting in suspension - either in-school or out-of-school, alternate program placement, or expulsion. It does not reflect the total number of students disciplined because each student can receive more than one disciplinary action during the school year. Table totals to 43,805 due to missing or invalid data on 35 cases.

Suspension policies vary by district. The type of disciplinary action imposed for each type of infraction varies according to school district policy. The definition of an infraction that results in disciplinary action also varies according to school district policy.

State operated schools are the Rhode Island School for the Deaf, Davies Vocational Technical School, and Metropolitan Career Tech.

Source of Data for Table/Methodology

Rhode Island Department of Elementary and Secondary Education, 1999—2000 school year.

References for Indicator

[i] Gaustad, J. (1992). *School Discipline*. Eugene, OR: ERIC Clearinghouse on Educational Management, ERIC Digest, Number 78.

[ii] National Center for Education Statistics (2000). *Indicators of School Crime and Safety*. Washington, DC: U.S. Department of Education.

[iii] National Center for Education Statistics (1999). *School Actions and Reactions to Discipline Issues*. Washington, DC: U.S. Department of Education

[iv] *Order in the Classroom* (1998). Princeton, NJ: Educational Testing Service, Policy Information Center.

[v] *The Condition of Education 1997* (1998). Washington, DC: National Center for Education Statistics.

[vi] *Unequal Discipline: New Data on Racial Disparities in School Discipline* (1999). Oakland, CA: Applied Research Center.

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High School Graduation Rate

DEFINITION

High school graduation rate is the percentage of the ninth-grade class that is expected to graduate, based on the existing drop-out incidence among 9th, 10th, 11th, and 12th grade students. The rate is computed using Fall enrollment data and the number of students who dropped out between October 2, 1998 and October 1, 1999. It is a four-year cumulative rate, and represents the probability of an individual student graduating from high school.

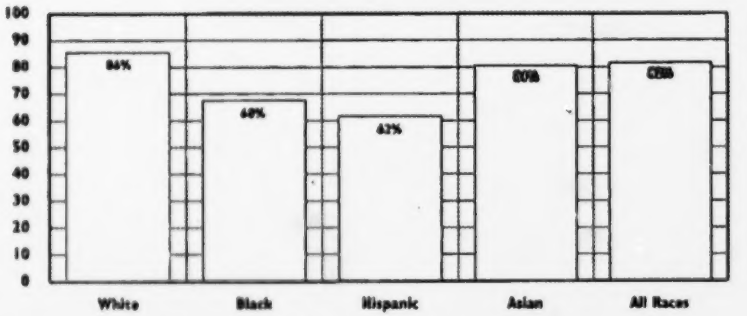
SIGNIFICANCE

Children who receive a quality education are more likely to grow into capable, productive adults who contribute to their communities. Social background factors such as limited English proficiency, family income, parent education, and family structure are associated with various levels of educational access and different educational outcomes.[1] Children and teens in economically disadvantaged communities are more likely to drop out of school.[2]

Student achievement can be improved when schools have high expectations for all students; effective and up-to-date curricula and teaching methods; prepared and sufficiently supported teachers; strong home/school linkages; adequate accountability systems; and effective and equitable allocation of resources.[3] Students can benefit from access to a broad range of community supports that address academic issues, health problems, inadequate nutrition, neighborhood and family violence, and other factors that can disrupt school performance.[4]

As a consequence of funding disparities, schools in low-income communities often have more limited access to up-to-date instructional materials, adequate classroom space, well-equipped libraries, laboratories, computers, and after-school sports and cultural activities.[5] Many children of color attend segregated schools with high concentrations of poverty and fewer resources. Hispanic children attend the most segregated schools.[6] Hispanic youth have lower high school completion rates than either Black, non-Hispanic or White, non-Hispanic youth.[7,8] In Rhode Island, 7% of the population but only 4% of college enrollees are Hispanic.[9] A recent national study found that an intensive high school curriculum had the strongest effect on African-American and Hispanic students' success in college; this factor was more significant than test scores, grade point averages, or class rank.[10]

High School Graduation Rate, by Race and Ethnicity, Rhode Island, 1999-2000



◇ Achievement differences among school districts, and among schools within a district, are correlated with the socio-economic status of the community or neighborhood.[11] These differences are also reflected in ethnic and racial disparities in high school graduation rates: In 1999-2000, the high school graduation rate in Rhode Island was 86% for Whites, 68% for Blacks, 62% for Hispanics and 81% for Asians.[12]

◇ In Rhode Island, 32% of White 25-65 year olds hold a bachelor's degree, compared to 16% for all other races. A recent national study indicates that if all ethnic groups in Rhode Island had the same educational attainment and earnings as Whites, total personal income in the state would be $228 million higher, and the state would realize an estimated $80 million in additional tax revenues.[13]

◇ Compared to other states, a low proportion of Rhode Island 11th and 12th graders in 1999 score well on college entrance exams and a very low proportion score well on Advanced Placement tests. In addition, along with New Hampshire and Maine, Rhode Island ranks lowest in the country in terms of the affordability of both public and private colleges and financial aid to low-income students.[14]

Table 31.

High School Graduation Rate, Rhode Island, 2000

SCHOOL DISTRICT	COMMUNITY CONTEXT						1999 GRADUATION RATE
	% CHILDREN IN POVERTY	% ADULTS COMPLETING HIGH SCHOOL	NUMBER OF STUDENTS ENROLLED	% LIMITED ENGLISH PROFICIENCY	% MINORITY ENROLLMENT	% OF STUDENTS TAKING THE SAT	
Barrington	2.3%	89%	3,183	0%	5%	83%	92%
Bristol-Warren	13.6%	NA	3,916	4%	3%	53%	79%
Burrillville	7.0%	71%	2,865	0%	2%	42%	85%
Central Falls	35.7%	47%	3,358	29%	69%	27%	63%
Chariho	8.7%	82%	3,955	0%	3%	49%	87%
Coventry	7.5%	74%	5,589	0%	3%	48%	89%
Cranston	10.9%	74%	10,924	4%	14%	56%	85%
Cumberland	4.8%	75%	5,135	2%	4%	65%	93%
East Greenwich	3.7%	90%	2,374	0%	4%	83%	95%
East Providence	9.7%	67%	6,623	7%	17%	53%	80%
Exeter-W. Greenwich	6.5%	78%	2,062	1%	4%	58%	84%
Foster	11.3%	82%	408	0%	2%	NA	NA
Foster-Glocester	8.3%	83%	1,586	0%	2%	59%	97%
Glocester	10.8%	83%	850	0%	2%	NA	NA
Jamestown	10.3%	89%	658	0%	4%	NA	NA
Johnston	10.0%	67%	3,524	1%	7%	52%	82%
Lincoln	9.5%	76%	3,702	1%	5%	68%	87%
Little Compton	3.5%	86%	348	0%	0%	NA	NA
Middletown	6.8%	85%	2,833	2%	13%	74%	93%
Narragansett	7.8%	87%	1,804	1%	8%	67%	84%
Newport	22.1%	84%	2,965	2%	35%	66%	88%
New Shoreham	9.5%	94%	126	3%	5%	100%	90%
North Kingstown	6.9%	86%	4,504	1%	5%	73%	89%
North Providence	7.4%	71%	3,518	3%	12%	55%	91%
North Smithfield	1.4%	72%	1,819	0%	2%	77%	92%
Pawtucket	17.6%	62%	9,904	12%	41%	45%	67%
Portsmouth	6.0%	86%	2,874	0%	5%	76%	94%
Providence	40.9%	63%	26,427	22%	81%	66%	63%
Scituate	5.3%	84%	1,750	0%	1%	78%	95%
Smithfield	4.5%	81%	2,747	0%	2%	70%	90%
South Kingstown	9.0%	86%	4,383	1%	10%	75%	87%
Tiverton	8.5%	71%	2,297	0%	1%	65%	90%
Warwick	9.0%	78%	12,264	1%	4%	58%	92%
Westerly	9.6%	76%	3,605	2%	5%	62%	83%
West Warwick	16.7%	70%	3,801	3%	9%	51%	75%
Woonsocket	22.3%	56%	6,670	6%	33%	53%	79%
Core Cities	*31.4%*	*NA*	*49,324*	*17%*	*63%*	*57%*	*NA*
Remainder of State	*8.5%*	*NA*	*106,027*	*2%*	*7%*	*60%*	*NA*
Rhode Island	*15.8%*	*72%*	*155,351*	*7%*	*24%*	*60%*	*82%*

Source of Data for Table/Methodology

% children in poverty is from the U.S. Bureau of the Census, Small Area Income and Population Estimates, Children Ages 5-17, 1997, released in November 2000. Percent of adults completing high school is from the 1990 Census of Population. All other data are from the Rhode Island Department of Elementary and Secondary Education, 1999-2000 school year.

The denominator is the number of children enrolled in 9th, 10th, 11th and 12th grades in the fall of 1999. NA: Community has a regional high school.

References

[1] *The Condition of Education 2000* (2000). Washington, DC: National Center for Educational Statistics.

[2] *Dropout Rates in the United States: 1998* (1999). Washington, DC: U.S. Department of Education, Office of Educational Research and Improvement, National Center for Education Statistics.

[3] *Years of Promise: A Comprehensive Learning Strategy for America's Children* (1996). New York: Carnegie Corporation of New York.

[4,5] *KIDS COUNT Data Book: State Profiles of Child Well-Being* (1997). Baltimore, MD: Annie E. Casey Foundation.

[6] Orfield, G. & Yun, J.T. (1999). *Resegregation in American Schools*. Cambridge, MA: The Civil Rights Project, Harvard University.

[7] *High School Dropouts by Race-Ethnicity and Recency of Migration* (June 2000). Washington, DC: U.S. Department of Education, Office of Educational Research and Improvement, National Center for Education Statistics.

[8] *America's Children: Key National Indicators of Well-Being 2000* (2000). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[9,10,11] *Measuring Up 2000: The State-by-State Report Card for Higher Education* (2000). Washington, DC: The National Center for Public Policy and Higher Education.

[10] Olson, Lynn (June 2, 1999). "Study Links High School Courses with College Success" in *Education Week*.

[11,12] RI KIDS COUNT calculations based on data from the Rhode Island Department of Elementary and Secondary Education, 1995 to 1999.

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Teens Not in School and Not Working

DEFINITION

Teens not in school and not working is the percentage of teens ages 16 to 19 who are not enrolled in school, not in the Armed Forces, and not employed. This indicator includes recent high school graduates who are unemployed, and teens who have dropped out of high school and are jobless.

SIGNIFICANCE

Dropping out of school and not becoming part of the workforce places teens at a significant disadvantage as they transition from adolescence to adulthood. These adolescents have a difficult time getting connected to the job market as young adults and have a less stable employment history than their peers who stayed in school or secured jobs.[1,2] In 1998, almost 4,000 (8%) Rhode Island teens ages 16 to 19 were neither enrolled in school nor working.[3] This group of teens is likely to lack credible references, have little confidence in their abilities, and lack knowledge about job opportunities.[4] They are also at especially high risk for teen parenting, crime, negative behaviors, and limited economic prospects as adults.[5,6]

Many school and community programs do not adequately address the needs of students on the verge of dropping out of school and out-of-school youth.[7,8] While economic growth in the United States and Rhode Island has created new jobs, many of these jobs are available only to those with higher skill levels.[9] All youth need opportunities to develop basic skills such as math, reading and writing. They also need to develop qualities that will help them find a job, including problem-solving, creativity, self-motivation, and responsibility.[10] Ongoing relationships with caring adults, connections within the family and community, and personalized guidance are powerful factors in protecting young people from negative behaviors, encouraging good social skills, responsible values, and positive identity.[11,12]

For those likely to leave school with no connection to the job market, school-linked, part-time jobs can be an important resource to prevent dropping-out, reinforce learning in school, and develop positive work attitudes and habits.[13] Many middle-class teens get their jobs through a network of informal contacts. Low-income teens are less likely to have these kinds of connections with employers and places of employment. Effective programs for out-of-school youth seek to construct (or reconstruct) these networks.[14] The most effective school-to-work programs have positive effects on students' attitudes toward work, school attendance, and dropout rates.[15]

Out-of-School Youth: National Trends

◇ The percentage of Black and Hispanic youth ages 16 to 19 who are neither employed nor in school exceeds that of White youth. In 1998, 13% of Black youth, 14% of Hispanic youth and 7% of White youth were neither in school nor employed.[16]

◇ Youth ages 18 to 19 are three times more likely to be neither in school nor working than youth ages 16 and 17.[17]

Jobs for Ocean State Graduates

◇ Jobs for Ocean State Graduates (JOSG) is the Rhode Island affiliate of Jobs for America's Graduates, the nation's largest most consistently applied model of school-to-career transition for at-risk and disadvantaged teens.

◇ JOSG is a comprehensive initiative designed to improve graduation rates and transition into work or postsecondary education and training programs.

◇ The program identifies high-risk youth based on factors such as excessive absences, excessive truancy or probation, behind grade level for age, personal or family problems, deficiencies in basic skills, poor academic performance, and/or lack of vocational skills.

◇ In the 1998-1999 academic year, of the 198 seniors participating in JOSG, 94% graduated from high school, 61% had full-time jobs, 15% went on to postsecondary education, and 78% had full-time placements in school or work.

◇ Since 1995, the program has served more than 1,200 students in 12 schools in Providence, Pawtucket, Woonsocket, Central Falls, Warwick, Smithfield, North Kingstown, East Providence, Bristol/Warren, and Tiverton.

Source: Jobs for Ocean State Graduates, Cranston, Rhode Island, Spring 2000.

Table 32. **% Teens Not in School and Not Working, Ages 16-19, Rhode Island, 1990**

CITY/TOWN	TOTAL NUMBER OF TEENS AGES 16-19	JOBLESS HIGH SCHOOL GRADUATES	JOBLESS NON-HIGH SCHOOL GRADUATES	TOTAL NUMBER OF JOBLESS TEENS	% OF TEENS WHO ARE JOBLESS
Barrington	800	8	17	25	3.1%
Bristol	1,703	43	34	77	4.5%
Burrillville	886	33	31	64	7.2%
Central Falls	931	35	100	135	14.5%
Charlestown	261	0	0	0	0.0%
Coventry	1,689	59	52	111	6.6%
Cranston	3,500	119	304	423	12.1%
Cumberland	1,474	59	128	187	12.7%
East Greenwich	627	0	7	7	1.1%
East Providence	2,408	72	180	252	10.5%
Exeter	279	16	17	33	11.8%
Foster	232	16	3	19	8.2%
Glocester	565	27	27	54	9.6%
Hopkinton	377	10	44	54	14.3%
Jamestown	226	0	10	10	4.4%
Johnston	1,235	13	30	43	3.5%
Lincoln	874	32	17	49	5.6%
Little Compton	167	0	4	4	2.4%
Middletown	922	20	27	47	5.1%
Narragansett	653	15	16	31	4.7%
Newport	1,978	56	46	102	5.2%
New Shoreham	20	0	0	0	0.0%
North Kingstown	1,269	12	30	42	3.3%
North Providence	1,444	29	78	107	7.4%
North Smithfield	578	30	0	30	5.2%
Pawtucket	3,632	81	303	384	10.6%
Portsmouth	851	10	13	23	2.7%
Providence	12,841	254	1,042	1,296	10.1%
Richmond	284	18	16	34	12.0%
Scituate	555	24	10	34	6.1%
Smithfield	1,625	21	16	37	2.3%
South Kingstown	3,818	15	7	22	0.6%
Tiverton	812	34	24	58	7.1%
Warren	505	0	37	37	7.3%
Warwick	4,231	151	198	349	8.2%
Westerly	992	10	108	118	11.9%
West Greenwich	211	15	0	15	7.1%
West Warwick	1,478	46	89	135	9.1%
Woonsocket	2,357	101	285	386	16.4%
Core Cities	***21,739***	***527***	***1,776***	***2,303***	***10.6%***
Remainder of State	***37,551***	***957***	***1,574***	***2,531***	***6.7%***
Rhode Island	***59,290***	***1,484***	***3,350***	***4,834***	***8.1%***

Sources of Data for Table/Methodology

U.S. Bureau of the Census, 1990 Census of Population.

Core cities are Providence, Pawtucket, Woonsocket, Newport and Central Falls.

The denominator is the number of teens ages 16 to 19 according to the 1990 Census of Population.

References

[1,3,4,5,7] *America's Children: Key National Indicators of Well-Being* (1998). Washington, DC: Federal Interagency Forum on Child and Family Statistics.

[2,8,12] Lerman, R. I.(May 16, 1996). *Helping Disconnected Youth by Improving Linkages Between High Schools and Careers.* Presentation at the American Enterprise Institute Forum, Americas Disconnected Youth: Toward a Preventative Strategy.

[3] US Bureau of the Census, Current Population Survey, 1996 to 2000 average.

[4] Rossi, R. and A. Montgomery, Eds. (January 1994). *Educational Reforms and Students At Risk: A Review of the Current State of the Art.* Washington, DC: U.S. Department of Education.

[5] *Skills, Standards and Entry Level Work: Elements of a Strategy for Youth Employability Development* (1995). Washington, DC: U.S. Department of Labor, Employment and Training Administration.

[6] *A Matter of Time: Risk and Opportunity in the Non-School Hours* (1992). New York: Carnegie Corporation.

[9] *Jobs for Ocean State Graduates, Executive Summary* (2000). Cranston, RI: Jobs for Ocean State Graduates.

[10,11] America's Promise: The Alliance for Youth (1997). *Five Resources All American Youth Need: How Are We Doing As a Nation.* Minneapolis, MN: The Search Institute.

[11] Dynarski, M. (December 2000). *Making Do With Less: Interpreting Evidence from Recent Federal Evaluations of Drop-Out Prevention Programs.* Princeton, NJ: Mathematica Policy Research Institute.

[13,15] *Job Opportunity Initiatives: Toward a Better Future for Low-Income Children and Youth* (1994). Minneapolis, MN: Rainbow Research, Inc.

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Methodology and Acknowledgements

Methodology

The *2001 Rhode Island KIDS COUNT Factbook* examines forty-three indicators in five areas that affect the lives of children: Family and Community, Economic Well-Being, Health, Safety, and Education. The information on each indicator is organized as follows:

- ***Definition:*** A description of the indicator and what it measures.
- ***Significance:*** The relationship of the indicator to child and family well-being.
- ***Sidebars:*** Current state and national data and information related to the indicator.
- ***City/Town Tables:*** Data for each indicator presented for each of Rhode Island's cities and towns, the state as a whole, and the core cities.
- ***Core Cities Data:*** Five core cities are identified based on high child poverty rates: Providence, Pawtucket, Woonsocket, Newport, and Central Falls. These are the only Rhode Island communities in which more than 15% of the children live below the poverty level, according to the 1990 Census.
- ***Most Recent Available Data:*** The *2001 Factbook* uses the most current, reliable data available for each indicator.
- ***New Indicators:*** Six new indicators have been added to the thirty-seven indicators included in the *2000 Rhode Island KIDS COUNT Factbook*: Racial and Ethnic Disparities, Secure Parental Employment, Children's Mental Health, Juveniles at the Training School, Out-of-Home Placements, and English Language Learners.

The *2001 Rhode Island KIDS COUNT Factbook* presents the data for each indicator using numbers, rates, and/or percentages.

Numbers

The most direct measure of the scope of a problem is the count of the number of events of concern during a specified time period — e.g. the number of child deaths between 1994 and 1998.

Numbers are important in assessing the scope of the problem and in estimating the resources required to address a problem. Numbers are not useful to compare the severity of the problem from one geographic area to another or to compare the extent of the problem in your state with national standards. For example, a state with more children might have more low birthweight infants due to the larger number of total births, not due to an increased likelihood of being born low birthweight.

Rates and Percentages

A rate is a measure of the probability of an event — e.g. out of every 1,000 live births, how many infants will die before their first birthday?

A percentage is another measure of the probability of an event — e.g. out of every 100 births, how many will be born low birthweight?

Rates and percentages take into account the total population of children eligible for an event. They are useful in comparing the severity of the problem from one geographic area to another, to compare with state or national standards, or to look at trends over time.

Sources of Data and Methodology for Calculating Rates and Percentages

For each indicator, the source of information for the actual number of events of interest (the "numerator") are identified within the Source of Data/Methodology section next to the table for that indicator. For each indicator that uses a rate or a percentage, the methodology used to estimate the total number of children eligible for the indicator of interest (i.e. the "denominator") is also noted within the Source of Data/Methodology section.

Rates and percentages were not calculated for cities and towns with small denominators (less than 500 for delayed prenatal care, low birthweight infants, and infant mortality rates and less than 100 for births to teens). Rates and percentages for small denominators are statistically unreliable. "NA" is noted in the indicator table when this occurs. In the indicator for child deaths and teen deaths, the indicator events are rare; in these instances, city and town rates are not calculated, as small numbers make these rates statistically unreliable.

Methodology for GeoLytics Estimates of 1999 Child Population

Child population for children under age 18 in 1999 are from GeoLytics, Inc.,"CensusCD + Maps," Version 3.0, Estimates and Projections Tables.

Data for Rhode Island cities and towns are the result of aggregating GeoLytics 1999 estimates for block groups up to census tracts and then aggregating census tracts to cities and towns. Direct city/town estimates are not possible using GeoLytics 1999. Aggregation of tract level data to state totals produces results that are significantly lower than state totals furnished by GeoLytics. Block group data aggregate to state totals that match those from GeoLytics.

Methodology for Children Receiving Child Support Indicator

Estimated Number of Children in the Child Support Enforcement System: This number is higher than in previous years because it includes Rhode Island children for whom the Child Support Enforcement Office collects and disburses child support payments, regardless of whether or not the Child Support Enforcement Office is providing the family with services related to paternity establishment or child support enforcement.

Estimated Amount Owed in Child Support: This amount is lower than in past years because the Child Support Enforcement Office reduced the total amount of arrears substantially, primarily by closing old cases

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and adjusting out overcharges on non-custodial parent's accounts after the child turned 18.

Methodology for Infant and Preschool Child Care Indicator

Estimated Number of Children in Need of Regulated Child Care: The denominator is the potential number of children in need of regulated care and is computed by: a.) multiplying the 1990 Census number of children under age 6 with mothers in the workforce by 47% (the percentage of U.S. women with children under age 6 who use center-based care or family child care homes as their child care arrangement), and adding it to b.) the number of 1 to 5 year olds living in families enrolled in the Family Independence Program as of December, 1999 that has been multiplied by 50% (assuming half of FIP mothers will work), and then multiplied by 75% (the percentage of families receiving child care subsidies in Rhode Island who choose center-based care or families child care homes as their child care arrangement). The number of regulated child care slots is the number of licensed full-time child care center slots for children under age 6 and the number of certified family child care home slots as of December 1999. Core cities are Providence, Pawtucket, Woonsocket, Newport, and Central Falls.

Methodology for Child Care Subsidies Indicator

Number of Child Care Subsidies by City and Town: The number of children receiving child care subsidies in a licensed child care center or a certified family child care home is the total number of children for whom the Rhode Island Department of Human Services paid a full or part-time subsidy as of December 2000. All data are based on the location of the child care program where the child receives services, not the residence of the child. Two child care programs, Child Care Connection and Child, Inc., have multiple centers and receive payment for all children at a central business office, not at the location of the center. For these programs, the number of children using subsidies in each city or town are estimates based on the percentage of total children using subsidies in each center as of January 2001.

Estimated Number of Children Under Age 16 Eligible for Child Care Subsidies: The number of children under age 16 in working families under 185% of the Federal Poverty Level (FPL) is computed by: a.) multiplying the 1990 Census percentage of women in the labor force with children under age 18 by the number of Rhode Island children under age 16 in 1999 (as computed by GeoLytics methodology) to get the total number of children under age 16 with mothers in the workforce; b.) The total number of children under age 16 with mothers in the workforce is multiplied by the percentage of children under 185% FPL (children eligible for free or reduced price school lunch) to get the estimated number of children under age 16 in working families under 185% of the FPL.

Methodology for Fourth Grade Reading Skills Indicator

As of 2000, the manner in which reading scores are calculated changed. In the past, a student was counted as a test taker only if they actually took the test and completed enough of it for a score to be calculated. As of 1999-2000, however, all students eligible to take the test are counted, whether or not they take the test. (All students are eligible unless their IEP specifically exempts them or unless they are Beginning English Language Learners.) As a result, overall proficiency rates, as reported here, are lower than they were under the previous system of scoring. For instance, in 1999, under the previous system of scoring, 84% of fourth graders were proficient in basic understanding and 69% in interpretation and analysis.

Limitations of the Data

In any data collection process there are always concerns about the accuracy and completeness of the data being collected. All data used in the 43 indicators were collected through the U.S. Bureau of the Census and through routine data collection systems operated by different agencies of the state of Rhode Island. We do not have estimates of the completeness of reporting to these systems.

In all cases, we used the most reliable data currently available. For census-based indicators, statewide numbers have been updated to 1998 using the Current Population Survey, 1996-2000 average. The Current Population Survey does not provide data at the level of city and town. City/town tables, therefore, use information from the 1990 Census of Population or Geolytics.

We expect that over time the data used to assess child well-being in Rhode Island will be more timely and will contain more complete information on the state's racial and ethnic communities than is currently available.

2000 U.S. Census

New data from the 2000 U.S. Census of Population were not available at the time the *2001 Rhode Island KIDS COUNT Factbook* went to press. We expect data from the 2000 U.S. Census of Population to become available in phases over the next two years. As the data become available, we will include the new information in future publications and on the Rhode Island KIDS COUNT website.

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Poetry Credits

"Barter" by Sara Teasdale, reprinted from *Favorite Poems Old and New* (1957). Garden City, New York: Doubleday & Co., Inc.

"The Home" by Rabindranath Tagore, reprinted from *The Golden Journey, Poems for Young People* (1965). Chicago: Reilly & Lee Company.

"Ancient Wisdom" by Francisco X. Alarcon, reprinted from *The Bellybutton of the Moon and Other Summer Poems* (1998). San Francisco: Children's Book Press.

"My People" by Langston Hughes, reprinted from *The Dream Keeper and Other Poems* (1932). New York: Alfred A. Knopf.

From "The Way to Start a Day" by Byrd Baylor, reprinted from *Tomie dePaola's Book of Poems* (1988). New York: G.P. Putnam's Sons.

"Dreams" by Langston Hughes, reprinted from *The Dreamkeeper and Other Poems* (1932). New York: Alfred A. Knopf.

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